EARLY WORKS & REFLECTIONS

Early Works, Reflections and Miscellaneous Papers

William L. White — Selected Papers, Volume X

145 Papers

White's early career writings, personal reflections, and papers that span multiple themes — including his foundational thinking on addiction counseling and the recovery field.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2002) Women, addiction, and recovery: A historical review. *Counselor*, 3(4), 52-54. Posted at **www.williamwhitepapers.com**

Women, Addiction, and Recovery: A Historical Review

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In the spring of 1978, First Lady Betty Ford publicly announced that she had begun her recovery from addiction to alcohol and other drugs. It was a stunning moment for those who had long worked to destigmatize addiction and convey hope for addiction recovery among women. Betty Ford's courage and candor boosted the women-focused research and treatment agendas of NIDA and NIAAA and sparked many local communities to examine the special needs of addicted women. Since then, research and treatment advances have forced a dramatic re-evaluation of the sources and solutions to alcohol- and other drug-related problems among women. This brief article sets these advances in the larger context of the history of addiction, treatment and recovery among American women.

The birth of gender-specific treatment

Addiction among women arose within two larger trends of the 18th and 19th centuries: a near tripling of annual per capita alcohol consumption between 1780 and 1820, and an increase in other psychoactive drug use in the decades that followed. The latter was influenced by the lack of medicinal alternatives to narcotics, and by a patent medicine industry that aggressively promoted alcohol-, opiate-, cocaine-, and chloral-laced products for women's "troubles."

Newly-formed temperance organizations decried the rise of inebriety among men and women. On May 12, 1841, the first chapter of the Martha Washington Society was founded in New York to provide support for inebriates, especially the female inebriate. Accounts of the Martha Washington Societies noted the successful reform of many female inebriates (Johnson, 1843). Other groups involved in female "rescue work" included the Daughters of Rechab, the Sisters of Samaria, as well as the Ladies Dashaway Association.

When the first medically oriented inebriate asylum opened in 1864, 400 of the first 4,000 applications for admission were from women. The recognition of the special needs of the female inebriate quickly led to the opening of the first gender-specific treatment program, the Martha Washington

Home in Chicago (1869). Other specialized women's programs followed, including the Temple Home (1876), the New England Home for Intemperate Women (1879), and St. Savior's Sanitarium (early 1890s) (White, 1998).

By dramatizing her moral degradation, the same temperance movement that reached out to the inebriate woman also increased the stigma attached to female addiction. It was this stigma that drove female addiction and its treatment underground. A woman seeking discrete treatment at the Keeley Institute in Dwight, Illinois, in the 1890s was often admitted under a false name with even her physicians unaware of her true identity. While the "Keeley Men" strolled the city streets and proudly posed for pictures of their triumph over "King Alcohol," women were sequestered in the "Ladies Home," isolated from male patients and exposure to local citizens, where they never appeared in Keeley photographs.

Nineteenth century addiction texts and the Journal of Inebriety sustained lively debates about the sources and solutions to female inebriety. Particularly striking in this literature, by their omission, are the voices of addicted and recovering women. In fact, the only biographical work of an addicted woman in the 19th century, Confessions of a Female Inebriate (1842), was penned by a man – Issac Shepherd.

The lone voices of women in the addictions literature of the 19th century were those working as professional helpers, two of whom deserve special mention. In 1888, Dr. Lucy Hall, Physician in Charge of the Reformatory Prison in Sherburne, Massachusetts, profiled 204 addicted, incarcerated women. Most began drinking as teenagers, usually drank with other young women, and progressed from alcohol-laced tonics to beer and spirits. More than one-third of the women had been battered by their husbands. A decade later, Dr. Agnes Sparks (1897, 1898) published a series of articles on the treatment of addicted women. She suggested that women had less genetic risk of inebriety, greater risk alcohol-related physical pathology, but a better prognosis for long-term recovery than did men when their special needs were addressed.

The collapse and rebirth of women's treatment (1900-1970)

Specialized treatment for women disappeared alongside the larger collapse of recovery support groups and treatment programs in the early 20th century. Ironically, the event that contributed most to the collapse of treatment resources, the advent of Prohibition, also changed women's drinking patterns. Women, who would never have entered the saloon, began entering the new nightclubs, cabarets, and speakeasies in great numbers and with great frequency. During this same period, opiate addiction among women declined under the influence of new drug control laws and improved physician training.

While the first voices of addicted women appeared in American literature between 1930 and 1940 (O.W., 1930; Wilson, 1940), most addicted women in the early 20th century lived and died in a shroud of silence. This began to change as the first women entered Alcoholics Anonymous in the 1930s and 1940s. The struggles of these first women in the "fellowship" of A.A. were poignantly detailed in *Grapevine* articles (Women, 1945, 1946). Women's groups began in A.A. in the early 1940s, and surveys of A.A. membership reflected a steady increase in female members from 15 percent in 1951, 22 percent in 1966, and on toward its current level of 34 percent.

Several heroic women helped shape the history of alcoholism treatment during the 1940s and 1950s. Marty Mann, the first woman to achieve prolonged sobriety within A.A., founded the National Committee for Education on Alcoholism in 1944. The repeated public testimony of her recovery from alcoholism brought innumerable women into recovery. Another such courageous disclosure was that of actress Lillian Roth, who announced her treatment for alcoholism in 1946 and detailed her recovery in *I'll Cry Tomorrow* (1954).

There were the women who began working in the front lines of alcoholism treatment during the 1940s and 1950s, physicians like Dr. Ruth Fox and Dr. Vernelle Fox, who pioneered new approaches to the treatment of alcoholism and helped organize what would later become the American Society of Addiction Medicine. There were nurses like Theresa ("Teddy") Rowan whose own recovery inspired her to work as a nurse on the alcoholism ward at Knickerbocker Hospital in New York City. There were local recovery advocates like Katherine Pike, Mary Ross, and Elizabeth Whitney, who organized local alcoholism councils. And there were administrators like Phyllis Snyder of the Chicago Alcoholism Treatment Center and Geraldine Delaney of Alina Lodge in New Jersey (Pioneers, 1979). All used their leadership positions to advocate for the special needs of addicted women.

Such advocacy was important as the addicted woman was being publicly portrayed in lurid images and language. Literature from the 1940s and 1950s featured lurid titles (*Tormented Women: A Frank Revealing Study of Women Degraded by Alcohol*) and subtitles like "Drink turned her into a sex-crazed animal!" Even magazine coverage of A.A. reflected such titles as, "A.A.: No Booze but Plenty of Babes." Similar caricatures were created out of women addicted to narcotics and other drugs in the literature of the late 1950s and 1960s (e.g., Dope Dolls, I Made My Bed).

Such was the cultural climate in which new specialized resources for women were developed in the 1950s and 1960s, programs like Friendly House in Los Angeles (early 1950s), Hazelden's Dia Linn in Minnesota (1956), the House of Hope Women's Residence in Utah (1956), and the Women's Center in Oregon (c.1958). Momentum was building for the rebirth of community-based treatment, and a rebirth of gender-specific treatment.

In 1969, Senator Harold Hughes led hearings before his Subcommittee on Alcohol and Narcotics. Two recovering women played prominent roles in the hearings, Marty Mann of the National Council on Alcoholism, and the Academy Award winning actress, Mercedes McCambridge, who publicly disclosed her recovery from alcoholism at the hearings. The legislation that grew out of these hearings marked the culmination of nearly two centuries of efforts to forge a community-based system of addiction treatment. Concerns about the special needs of women rose once again, and have sparked a new era of gender-based research and treatment.

Enduring themes

Although we have explored only a few snippets of the history of addiction and recovery among American women, enduring themes abound. First, there is the targeting of women by the promotional machinery of licit and illicit drug industries. Second, there is the long history of stigma, and the resulting invisibility and voicelessness of addicted and recovering women. Third, there is the amazingly resilient assumption that women's lives can be changed within programs created by and for men. Finally, and most importantly, there are the women who have used their lives as instruments of service to other women, who have forged new metaphors and rituals of transformation, and who have served as the stateswomen in the larger arena of addiction treatment and recovery advocacy.

Everything we have studied in the addictions arena - etiologies, patterns, obstacles, engagement strategies, treatment techniques, and styles and structures of recovery reveal significant gender differences. We owe much to our modern pioneers, Jean Kirkpatrick, Marian Sandmaier, Edith Gomberg, Sharon Wilsnack, LeClaire Bissell, Sheila Blume, Linda Beckman, Charlotte Davis Kasl, and Stephanie Covington, to name just a few, who have tried to push these findings from the laboratory to the community. They have widened the doorways of recovery by helping create intervention and recovery models designed for women.

It is not enough that a few premier, gender-specific programs existed for brief periods in American history, or that a few such model programs exist today. It is time that all we have learned about the treatment of addicted women is mainstreamed in treatment programs throughout the country. The day that a woman could enter an addiction treatment program anywhere in the country and find treatment designed for her has been a vision for more than 150 years. It is time that vision was fulfilled.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2003) A history of contempt: Countertransference and the dangers of service integration. *Counselor*, 4(6), 20-232. Posted at **www.williamwhitepapers.com**

A History of Contempt: Countertransference and the Dangers of Service Integration

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Introduction

One of the most significant contributions psychoanalysis made to the development of human service interventions was the elucidation of the twin complexities of the helping relationship. The concept of *transference* suggested that client's experiences in their most significant prior relationships were projected into their relationship with the professional helper. The concept of *countertransference* suggested that the professional helper's past relationships and feelings were similarly elicited and projected in unique ways onto each client. In psychoanalytic thinking, the manner in which these transferences and countertransferences went unseen or were actively managed was thought to dictate the outcome, good or bad, of the helping process.

Countertransference is the "total emotional reaction of the therapist to the patient"–a reaction that involves the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991). Countertransference is composed of both collective sentiments (those based on categorical responses to such issues as race, gender, age, sexual orientation, and problem type) and idiosyncratic sentiments (those based on unique emotional reactions of the therapist to a particular client). This article will 1) review the history of a particular type of countertransference that has often marred the relationship between professional helpers and those addicted to alcohol and other drugs, 2) describe the unique antidote that mutual aid societies and addiction counselors brought to that problem, and 3) raise concerns about the intensification of countertransference problems amidst the current wave of service integration initiatives.

Addiction and the Therapeutic Encounter

Addiction to alcohol and other drugs is often wrapped within an elaborate defense structure created in response to the loss of control over alcohol or drug use, the social stigma attached to addiction, and the heightened vulnerability of the therapeutic encounter. Over time, this primitive defense structure is exaggerated and frozen into a

self-fulfilling view of self and the world. It is not surprising then that addicts develop chronic self-defeating styles of interacting with professional helpers via passivity (superficial charm, temporary compliance, flight into health, social withdrawal) or aggression (justifying, blaming, acting out, intimidating, fleeing) (White, 1996).

Professional helpers bring their own emotional responses to addicts and their defensive gambits. Cohen, White and Schoolar (1971) ask, "How does one move unflinchingly into an arena where he or she is made to feel unwanted, incompetent and even malevolent?" The historical answer to this question is that helping professionals have avoided such discomfort by excluding addicts from various service contexts or by becoming over-involved, engulfed and embittered in such encounters. It is at these extremes that professional helpers have been guilty of ethical breaches that range from clinical abandonment (disrespect, emotional detachment, avoidance, and service extrusion) to enmeshment (rescuing, emotional fusion, intimacy violations).

Cycles of Contempt and Respect

While professional counter-transference can stem from highly personal sources, it can also flow from larger cultural attitudes toward those addicted to alcohol and other drugs. Views toward persons with severe alcohol and other drug problems have vacillated among the public and among helping professionals. There are eras in which addicted persons are defined as morally inferior (dangerous "fiends") and subjected to systems of sequestration and punishment. These eras create the stigmatized soil out of which recovery mutual aid societies and specialized addiction treatment institutions are spawned. There are also eras in which persons addicted to alcohol and other drugs are viewed as our family members, friends, neighbors and co-workers–people viewed as morally worthy of our compassion and care. As attitudes toward addiction soften, the care of addicts evolves through the creation of specialized institutions to their integration into more mainstream service systems. These cycles of categorical segregation and integration define the types of institutions in which addicts find themselves, and they shape the attitudes of the staff they encounter within those institutions. Such cycles can be illustrated through a few snippets of history.

In 1833, social and professional attitudes toward the alcoholic were described as follows: "they repulse the drunkard from their doors; neglect his sufferings; and whenever they meet him, manifest their contempt and abhorrence of him" (Sigorney and Smith, 1833, p 38). In the face of such attitudes, it is not surprising that alcoholics were perceived as morally unworthy to receive care in hospitals and psychiatric asylums. The Washingtonian revival of the 1840s created a sanctuary for the stigmatized alcoholic: "The drunkard is now regarded in a new light....Instead of being considered a cruel monster–a loathsome brute–an object of ridicule, contempt and indignation, as formerly, we are now taught to look upon him as a brother...as a slave to appetite, and debased by passion–yet still as a *man, our own brother*" (A Member, 1842, p. 65). The Washingtonians brought, in addition to a technology of recovery initiation (the public pledge, mutual surveillance, and service to others), a new attitude of regard and respect for the alcoholic. The inebriate homes and asylums of the nineteenth century were similarly birthed out of the belief that only in a specialized institution could the inebriate find the respect and care essential for his or her full recovery.

In the early 1870s, two recovering alcoholics, Jerry McAuley and his wife Marie, founded the Water Street Mission in New York City, marking the formal beginning of faith-based recovery ministries. One of McAuley's biographers described the Mission as a place where "men and women burdened with sin, broken down and shattered by debauchery and vice, homeless and hopeless, hungry, ragged and defiled, drunk or sober, fresh from prison or the gutter, are welcomed, are made to feel that somebody cares for them and that their wretched past has not made decency and

respectability in this life and salvation in the life after impossible to them...." (Offord, 1885, p. 176-177). The rescue missions were a reaction to the climate of social contempt and the failure of mainstream religious institutions and the larger community to reach out to the suffering alcoholic and addict.

When the nineteenth century network of inebriate homes and asylums collapsed in a wave of therapeutic pessimism that culturally redefined addiction in moral terms, alcoholics and addicts were cloistered into inebriate penal colonies, the back wards of aging state psychiatric hospitals, or in expensive, but discreet, private drying out facilities. Two stories illustrate the unwelcome reception they encountered in these institutions.

Marle Woodson was legally committed to Eastern Oklahoma Hospital, a state psychiatric asylum, in 1931 after having spent thousands of dollars on treatment in private psychiatric institutions. When the physician assigned to treat him first entered his room, Woodson extended his hand to shake hands with the doctor. Woodson describes what happened: "The look which the doctor gave me simply set me back on my heels. My hand remained untaken...Then I realized with a shock that this was not a meeting of two gentlemen on a plane of equality. In the eyes of the man before me, I was just another insane patient" (Woodson, 1932, p. 7).

The noted American author Willie Seabrook was admitted to Bloomingdale Asylum for the Insane for treatment of alcoholism in 1933. Seabrook's psychiatrist, reflecting the attitudes of many professional helpers toward alcoholics during this time, complained to Seabrook, "every time we've taken a drunk in this place, we've regretted it." (Seabrook, 1935). Such professional contempt was the norm in this era of non-specialized treatment.

The "modern alcoholism movement" (Alcoholics Anonymous, the Research Council on Problems of Alcohol, Yale Center of Alcohol Studies and the National Committee for Education on Alcoholism) rose out of the soil of such stigma. Why did the pioneers within these institutions champion a segregated system of care for the addicted? Because they had come to believe that alcoholics and addicts could never be helped in mainstream institutions permeated with such attitudes. As a result, alcoholics found entrance into new hospital-based alcoholism units cared for by people like Sister Ignatia (known as the "Angel of Alcoholics Anonymous") and Dr. William Silkworth (known as the "little doctor who loved drunks"). Their achievements were more attitudinal than technical. Marty Mann, a central figure in the modern alcoholism movement, declared that the key to successful treatment "is accepting the other person just as he is, for exactly what he is....it accords him the dignity of his humanity quite apart from his illness which may have buried that humanity deep out of sight." (Mann, In Staub and Kent, 1973, p. 3)

The field of addiction treatment emerged as a segregated field of professional service in the 1970s because the lay and professional leaders of that field were convinced by their study of history and their own collective experiences that alcoholics and addicts would not be welcomed nor would they ever get the care they needed within mainstream mental health, public health and social service agencies. The majority of those who birthed this specialty field knew from their own personal experience just how inept mainstream institutions were at treating the alcoholic/addict and that the best interests of alcoholics/addicts were unlikely to be served in such institutions. They also knew that this was a failure both of technology (misguided assumptions and ineffective methods of intervention) and of attitudes. Those understandings became the impetus for a re-birthed field of addiction treatment and new specialty roles in addiction medicine and addiction counseling. While there have been many technical breakthroughs in the specialized arena of addiction treatment, what these new roles most contributed was a revival of respect for those impacted by addiction and a willingness to enter into service relationships characterized by

authentic emotional contact and mutual vulnerability.

Countertransference and Service Integration

The progressive restigmatization, demedicalization and recriminalization of the past two decades threatens to end the era of revived respect in which most of us have pursued the profession of addiction counseling. Alcoholics and addicts are being moved in large numbers from systems of care to systems of control and punishment. Addiction treatment programs are facing a wave of service integration initiatives that threaten their character and their future. Four things have allowed addiction treatment practitioners to shun the cultural contempt with which alcoholics and addicts have long been held: 1) personal experiences of recovery and/or relationships with people in sustained recovery, 2) addiction-specific professional education, 3) the capacity to enter into relationships with alcoholics and addicts from a position of moral equality and emotional authenticity (willingness to experience a "kinship of common suffering" regardless of recovery status), and 4) clinical supervision by those possessing specialized knowledge about addiction, treatment and recovery processes. We must make sure that these qualities and conditions are not lost in the rush to integrate addiction treatment and other service systems.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Kurtz, E. and White, W. (2003, 2011). Alcoholics Anonymous. In Blocker, J. and Tyrell, I., Eds. *Alcohol and Temperance in Modern History*. Santa Barbara , CA: ABC-CLIO, pp. 27-31. Posted at www.williamwhitepapers.com

Alcoholics Anonymous

Ernest Kurtz, Ph.D. and William L. White, M.A.

According to the presentation of itself read at the beginning of most meetings of Alcoholics Anonymous:

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions.

AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes.

Our primary purpose is to stay sober and to help other alcoholics to achieve sobriety.

Beginnings: 1935-1950

Alcoholics Anonymous (AA) began on 12 May 1935, when a recently sobered broker's representative from New York, while visiting Akron, Ohio, experienced a craving for alcoholic refreshment and, to stave it off, sought out an alcoholic local surgeon. The visiting New Yorker was William Griffith Wilson; the surgeon was Dr. Robert Holbrook Smith. Eventually, they would be known as “Bill W.” and “Dr. Bob,” cofounders of Alcoholics Anonymous.

But not immediately, for Dr. Smith, attending a medical convention in Atlantic City, New Jersey, went on “one last toot.” Dr. Bob's sobriety date is usually given as 10 June 1935, which has become known in AA as “Founders’ Day,” despite recent evidence that Dr. Smith took his last drink on 17 June 1935. The exact date makes little difference. What was important about the first meeting between Wilson and Smith were three discoveries made by the two men in the course of that meeting.

First, they discovered the role of “the spiritual.” Bill Wilson located Dr. Bob Smith through a “spiritual” connection. Wilson was introduced to Smith by Henrietta Seiberling, a member of the Oxford Group. Seiberling’s name had been given him by an Oxford Group-oriented minister. Bill had joined the group after his own “spiritual experience” while sobering up in Towns Hospital in New York City in December 1934. The message underlying that experience originated with Dr. Carl Gustav Jung's observation that those in the second half of life could recover from alcoholism only through some kind of

"spiritual conversion." The Oxford Group was the leading vehicle for such conversion among middle-class Americans in the 1930s. Although much extended in meaning, the centrality of the "spiritual" has always characterized Alcoholics Anonymous.

The second discovery was the need to "carry the message." Wilson had tried to carry the message to other drunks in New York, but he found no one interested. His meeting with Dr. Smith, soon reinforced by their approach to "AA #3," Bill D., was different because in these cases they made the approach for their own sakes, not primarily to help the person they approached. The only way to keep their own sobriety, they discovered, was to give it away.

The third discovery was the importance of identification by way of story. Just before Wilson left for Akron, his physician, Dr. William Duncan Silkworth, cautioned him to stop emphasizing his "spiritual experience" when he approached other drunks. Silkworth, who viewed alcoholism as an allergy, urged Bill to "Give them the medical business." "Fine idea," Bill thought some weeks later in Akron, but how could he teach medicine to a physician? So Wilson fell back on telling his own story—the story of his life as it was affected by alcohol and the story of his recovery without alcohol. And Dr. Bob Smith identified; he recognized his own experience in Bill's autobiographical tale. The only way an alcoholic could get through to another alcoholic was by identification, and the only way to achieve that was by the mutual sharing of stories.

The Writing of the AA Big Book

Although the Oxford Group was the womb within which Alcoholics Anonymous came into being, AA left those auspices in 1937 in New York and in 1939 in Akron. The departure came mainly because of the Oxford Group's intrusive spirituality in such practices as group "guidance," and the group's focus on "the four absolutes" of honesty, unselfishness, purity, and love. Those virtues, Wilson later wrote, "are sought and practiced by members of Alcoholics Anonymous as much as by any other people, but if you put the word 'absolute' in front of them, alcoholics just couldn't stand the pace [and got drunk again]." In New York, those who left began to refer to themselves as "a nameless bunch of drunks"—a term that would be transmuted into "Alcoholics Anonymous" as the group later sought a title for its book.

In the early enthusiasm of their separate existence, some members proposed large projects such as hospitals. Largely due to Dr. Smith's urging to "Keep it simple," all designs other than writing a book detailing their method were discarded. Wilson began drafting what would become the book Alcoholics Anonymous, and the "alcoholic squadron" of the Oxford Group in Akron and the newly dry who met weekly at the Wilson residence in Brooklyn offered comments and suggestions. When published, the tome became known as the "Big Book" because the New Yorkers urged their printer to use the thickest paper available for the first edition so that it would seem worth the price to the generally impecunious alcoholics at whom is was targeted.

No groundswell of welcome greeted the publication of AA's book. Medical journals panned it. Attempts at publicity, such as a massive mailing of postcards to physicians, fell flat. But slowly, through newspaper coverage, most importantly through a 1941 article by investigative reporter Jack Alexander in The Saturday Evening Post, the public—and especially some drinking alcoholics—heard of AA. Some of those who heard contacted the listed New York office to purchase copies of the book.

Early Outcomes

The members' original intention was that individual alcoholics would read the book, "make surrender," and carry the message to other alcoholics. Meetings were for newcomers: "We meet frequently so that newcomers may find the fellowship they seek." Another purpose of the weekly meetings, now in Cleveland as well as in

New York and Akron, was to provide a forum for answering the questions of newcomers. Alcoholism was a puzzling malady to those who suffered it. Their earlier attempts at sobriety had failed. Why did AA work? And what about…whatever? But meetings did not become question-and-answer sessions—most of the early sober alcoholics were acutely aware that they had no "answers." There developed, rather, a practice that would be enshrined in the Preamble as "sharing their experience, strength and hope." Questions were answered by someone who identified with the questioner; the "answer" consisted of telling how a similar situation had worked out in his life. ("His" is used here because at this point, there was only one female member each in New York, Washington, and Chicago.)

Meanwhile, another need surfaced—the need for detoxification rather than what would later be termed "treatment." Alcoholics who could get to Akron were hospitalized for detoxification under the care of Dr. Smith. But not all drunks could go to Akron. Some few did not require large medical intervention, but most who approached Alcoholics Anonymous in those early years had severely damaged their health during their drinking. These people obviously needed hospitalization, but in those days, most hospitals did not admit alcoholics, mainly because they rarely paid their bills. This was how the practice of "sponsorship" began within Alcoholics Anonymous, first in Cleveland, then more widely. The "sponsor" was someone who promised to pay the detoxification hospital bill if the new recruit failed to do so. Sponsorship soon evolved into a more comprehensive concern for the individual newcomer's sobriety.

Following the example of the program devised by Dr. Smith and Sister Ignatia at Saint Thomas Hospital in Akron, a five-day hospital program opened at Knickerbocker Hospital in New York City by 1945. After the war, this type of program became available in other cities as well. Usually, a local physician, impressed with the success at sobriety of former patients, helped them set up an "AA ward" in the hospital. The medical care consisted of detoxification and nutritional buildup, and the usual program ran five days. During that time, the patient was allowed no outside distractions but was visited virtually around the clock by members of AA. Early on, a truism was discovered: "AA is for those who want it, not those who need it." Many who patently needed AA did not want it, and so did not get it. This observation led some Philadelphia physicians to begin keeping track of AA success. In 1937, Dr. Silkworth and Bill Wilson had both expressed the opinion that AA was unlikely to work for more than "about half" of what were then generally termed "chronic inebriates." The Philadelphia study suggested that AA was actually more successful. Among "those who really tried," it was found, about 50 percent achieved dryness almost at once, within a period of about 90 days, while another 25 percent did so after going out and drinking again but then coming back to AA. The final 25 percent seemed beyond AA's help.

These are important figures. In later years, when the popularity of "treatment" and the practice of employer coercion and court mandates forced more individuals to attend AA meetings, it appeared that less than 5 percent of those who attended an AA meeting got sober. What had been forgotten was the "really tried" part. Although never spelled out in detail, "really trying" was generally understood to consist of at least 90 days of fairly regular attendance at AA meetings, getting a sponsor, reading the literature, and attempting to work the Twelve Steps. As the twenty-first century unfolds, the 50-25-25 ratio first found in Philadelphia in 1946 still holds true for those who "really try."

The End of the Beginning

The World War II years saw the debut of AA's "unofficial" but significant publication, The AA Grapevine. Begun in June 1944 as a means of keeping in touch "with our boys in the armed forces," this journal has to this day continued monthly publication of members' sharing of their "experience, strength and hope." The magazine soon began to serve

another purpose in the great postwar expansion into sprawling new suburbs and a vibrant new consumer economy. From the beginning, given its Akron and New York City origins, a keynote of Alcoholics Anonymous was variety. As meetings developed more widely, they took on different formats: speaker, several speakers, one topic discussion, open discussion, and so forth. Similarly, the attitudes of groups and members toward such topics as "the spiritual" and "other drugs" varied. The AA Grapevine offered a forum in which these various approaches could be presented and discussed. The AA Grapevine's welcoming of such diversities marked the culmination of AA's first decade of existence. Between 1935 and 1945, the fellowship grew from 2 members to 12,986 members, organized into 556 local groups.

The trial-and-error development that took place in each new location led to a desire to learn from the experience of other groups. An attempt to produce a general handbook failed in the mid-1940s, though many locations developed their own guides, setting forth the practices of the locality for the edification of new groups. By the late 1940s, Bill Wilson began to review the growing correspondence in which members told of what worked and what did not work in their situations. When some wrote asking advice on a matter, Wilson and others in what became AA's General Service Office developed a practice of telling what had happened in similar circumstances in other settings. There thus emerged the "Twelve Traditions of Alcoholics Anonymous," initially promulgated in 1950 at the fellowship's first international convention held at Cleveland, Ohio. The traditions emerged during a period of explosive growth for AA; by 1950, membership exceeded 96,000 and local groups numbered more than 3,500. Though this would not become apparent until much later, AA's Twelve Traditions became to the existence of the fellowship what the Twelve Steps are to the sobriety of its individual members.

Coming of Age: 1951-1970

The promulgation of its Twelve Traditions in 1950 marked the beginning of AA's "Coming of Age," though that would not be formally celebrated until its 1955 Saint Louis convention. The 1950 convention marked Dr. Bob Smith's last public appearance before his death in November of that year. Two significant developments marked the early 1950s, developments that would continue to unfold in the following two decades. The first was the large social acceptance bestowed on Alcoholics Anonymous in the United States. Second, during this half-decade, Bill Wilson produced a book, Twelve Steps and Twelve Traditions, that guided many members' understanding of "the spiritual" during the changing times of the 1960s and 1970s.

From its earliest days, Alcoholics Anonymous had won support from many physicians and members of the clergy. The medical and religious professions generally welcomed the new fellowship and its program, which honored their contributions and even claimed a kind of joint origin from them. The Eisenhower decade of the 1950s proved an ideal setting for "the spiritual rather than religious" program of Alcoholics Anonymous to attain wide acceptance. Practically as well as symbolically, that acceptance came less with AA's winning of the 1951 Lasker Award or the congratulatory telegram President Dwight Eisenhower sent AA on the occasion of its twentieth-year "Coming of Age" convention than in the regular recommendation of the fellowship by advice columnists Ann Landers and Dear Abby. Reinforcing this acceptance were the movies Smash-Up and The Lost Weekend, eventually followed by Days of Wine and Roses and references that, though less focused on Alcoholics Anonymous, by that very fact attested to the broad basis of its cultural acceptance.

Throughout this period, AA's Twelve Traditions offered guidance that helped the fellowship resolve many troublesome issues, though not always unanimously. The establishment of "a desire to stop drinking" as "the only requirement for membership," the exclusion of "outside issues," the "one primary purpose" of carrying the AA

message “to the alcoholic who still suffers”—each in time would be challenged, and following the principle of “group autonomy,” some groups would opt for broad interpretation. But at least until the impact of commercialized “treatment,” AA remained not only recognizably but unambiguously the AA that had been founded in 1935.

As the 1960s progressed, AA cofounder William Griffith Wilson suffered increasing health problems, especially emphysema. Wilson’s last public appearance was at the Alcoholics Anonymous thirty-fifth annual convention at Miami Beach in 1970, where he had to be physically propped up to appear momentarily before the cheering throng. He died on 24 January 1971. At his death, there were more than 16,000 local AA groups and more than 310,000 members.

Few organizations led for so long by a charismatic leader survive his or her demise. Alcoholics Anonymous both refuted and bore out this generalization. AA refuted it in that, given its reverse-pyramidal, bottom-up structure, the individual groups and most members kept on functioning as they always had: carrying the message, living out the Twelve Steps of their program. Few people dropping into an AA meeting in the mid-1970s heard mention of Bill Wilson. But on a deeper level, the vacuum of leadership occurred at the dawning edge of a monumental change in cultural attitudes toward alcoholism, a change for which AA was partially responsible.

The Treatment Era: 1970-2000

From their beginnings, local AA groups carried their message of hope to alcoholics in missions, general and psychiatric hospitals, prisons, halfway houses, sanatoria, and various “drying out” facilities. During the middle decades of the twentieth century, AA members created sober sanctuaries (“AA farms,” “AA retreats,” “Twelve Step houses”) in communities where institutional support for recovery was lacking. AA members—as individuals, not as representatives of AA—were also heavily represented among the leaders of newly forming alcoholism councils, who advocated the establishment of local alcoholism information and referral centers, detoxification facilities, and rehabilitation programs. Under the leadership of the National Council on Alcoholism (NCA), this sustained advocacy campaign culminated in passage of the 1970 Comprehensive Alcoholism Prevention and Treatment Act, the landmark legislation that launched the modern alcoholism treatment field. With this infusion of federal funding, alcoholism treatment facilities in the United States grew in number from less than 200 in 1970 to 4,200 in 1980, 9,000 in 1990, and to more than 13,000 in 2010.

Directly, this new social development had nothing to do with AA, but many AA members played roles—as alcoholism counselors, nurses, physicians, and administrators—in the emergence and evolution of modern alcoholism treatment. Most of these new institutions also incorporated AA’s Twelve Steps into their treatment philosophies and recommended that their clients affiliate with AA during and following their professional treatment. This incorporation of AA philosophy was particularly pronounced in the “Minnesota Model”—a style of chemical dependency treatment that became the dominant approach to the treatment of addiction in the United States. By the mid¬1970s, professional concern was voiced about the inordinate influence AA was exerting on alcoholism treatment in the United States. Within a decade, there were equal concerns about the influence the treatment field was exerting on AA.

For as the treatment field grew into a treatment industry, it came to exert considerable influence on AA. The most immediate effect was growth. Between 1970 and 1980, AA membership rose from 311,450 to 907,575, and the number of local AA groups jumped from 16,459 to 42,105. By 1990, AA membership had further increased to 2,047,469 (93,914 groups). This dramatic growth was accompanied by the adaptation of AA’s Twelve Steps to every imaginable problem. “Recovery” became something of a cultural phenomenon as the concept of

"addiction" became applied to processes as well as to substances, and twelve-step groups were inundated by people bearing an endless list of unmet needs. This popular invasion created a transience in AA that was masked within the raw growth figures.

The growing percentage of people who entered AA while in treatment and the growing number of external bodies coercing people into AA combined to raise serious concerns within the organization. The fellowship did not remain passive in the face of such impacts. It reasserted the importance of its traditions on everything from anonymity to nonaffiliation; it issued guidelines for AA members working in the alcoholism field; and it published literature seeking to distinguish AA from treatment and to define the relationship between AA and treatment. These efforts, however, did little to stem the growing concern that AA's spiritual program of recovery was, through the influence of treatment and the criminal justice system, being watered down by "New Age" pop psychology at the same time it was taking on a coercive dimension. Many longtime AA members began to lament the secularization of AA, and several serious students of Alcoholics Anonymous began to distinguish between the elements of a "real" AA, characterized by the language of spirituality enshrined in the Twelve Steps, and an ersatz "twelve-step movement" employing the vocabulary of therapy, which—however helpful to some—marked an abandonment of the classic Alcoholics Anonymous insight and approach.

Under the impact of treatment-program needs, the early insight that "AA is for those who want it, not those who need it" became reversed. In their quest for customers, many treatment-oriented advocates focused on those they deemed to be in need of the AA program: judges as well as some therapists began "sentencing" individuals to attendance at AA meetings. This development soon made social-scientific research on Alcoholics Anonymous virtually impossible, for it overlooked the key phrase that appears in the Foreword to the second edition of the book Alcoholics Anonymous: "Of alcoholics who came to A.A. and really tried" [emphasis added]. It is impossible to measure "really tried," though some observant researchers have suggested rough outlines.

Meanwhile also, in part as a reaction to the infusion of "treatment thinking" in some gatherings calling themselves "AA," there also developed a growing fundamentalist movement within AA itse1f, one that sought to regain the practices of AA's earliest generations, though often at the cost of confusing Alcoholics Anonymous itself with its Oxford Group parent. The effort to distinguish between AA and outside enterprises that in one way or another attempted to clothe themselves in its reputation became increasingly important as the alcoholism treatment industry experienced both ideological and financial backlash during the late 1980s and 1990s. All this led not only to visibility but also to a new vulnerability for Alcoholics Anonymous. By the early 1990s, more than 3,000 books and articles had been written about this "simple" program of recovery. But heightened visibility invited public and professional criticism.

AA Critics

Serious criticism of AA began with a 1964 magazine article by psychologist Arthur Cain and accelerated rapidly during the 1980s and 1990s. Such criticisms were often entwined with broader attacks on the disease concept of alcoholism (often erroneously attributed to AA) and the alcoholism treatment industry. Critics included philosophers, psychologists, and sociologists, as well as groups advocating alternative alcoholism recovery approaches. The latter included the first nationally visible alternatives to Alcoholics Anonymous: Women For Sobriety (WFS), Secular Organization for Sobriety (S0S), Rational Recovery (RR), and Moderation Management (MM). By the mid-1980s, extremist critics of AA coalesced into something of a countermovement with their own publishing genre, star speakers, and Internet websites. The growing acrimony toward AA was revealed in such book titles

as Alcoholics Anonymous: Cult or Cure?, How Alcoholics Anonymous Failed Me, and Twelve-Step Horror Stories, as well as Internet websites bearing such names as AA Kills, AA Deprogramming, and Recovery Liberation.

The critics of AA argued that: (1) AA is not effective or (more conservatively) its effectiveness has not been scientifically established, (2) AA works only with particular types of alcoholics and may be harmful to other types, (3) AA's religious ideas and language discourage many alcoholics from seeking help, (4) AA is just a substitute dependence, and (5) AA has discouraged the scientific advancement of alcoholism treatment.

In response to critics and prominent media coverage of celebrity addiction and relapse stories, many AA members became interested in AA's own story and a new generation of researchers began to test scientifically the propositions surrounding the debate of AA's effectiveness. The former created an expanded body of literature on the history of AA, including a flurry of new biographies of early AA figures, particularly Bill Wilson. The latter created a growing body of scientific studies of AA's effectiveness and its "active ingredients" that were noteworthy for their increased methodological rigor. Keith Humphreys, for example, tested the proposition that AA was ineffective for women, people of color, and persons experiencing co-occurring psychiatric illness. Humphreys found that individuals from these groups affiliated with and successfully recovered within AA at rates comparable to white males.

Varieties of AA Experience

A trend within AA as important as AA's dramatic growth and its public attention is the continuing and growing variety of AA experience. Such variety is not new, as anyone familiar with the differences between New York and Akron AA in the 1930s realizes. Much of the quiet humor within Alcoholics Anonymous is rooted in the realization that no one will ever lead alcoholics very far in any direction—an alcoholic is by definition one who cannot be led. And so, not only is AA membership diverse but so are AA rituals, meeting practices, formats, outside-of-meeting events, and understandings of anonymity. Such diversity is an enduring phenomenon in AA, and this theme of diversity continues to be reflected in AA membership, in the growing propensity of local AA meetings to be organized around special populations or needs, and in the wide range of styles through which people "work" the AA program.

Membership surveys portray this: the 1996 and 1998 surveys reveal a membership increasingly diverse in age, gender (34 percent women), racial composition (12-14 percent non-white), and occupational background. Most AA members attend more than two meetings a week and more than 70 percent have been sober more than a year, with nearly half having been sober more than five years. The major factors bringing people to AA are self-motivation and contact with another AA member, closely followed by referral by a treatment or counseling agency, or by court order. Surveys cannot fully convey the diversity of AA experience, but local meeting lists reflect the growing specialization of the process of member-to-member identification within AA, including meetings by gender (women only), age (young people, "old-timers"), language (Spanish, no profanity), sexual orientation (gay, lesbian, bisexual, transgender), relationship status (singles, couples), co-occurring problems (HIV/AIDS, psychiatric illness), and smoking status (nonsmoking), to name a few of the most common demarcations. But even these categories do not fully express the multidimensional character of AA groups—groups that differ dramatically in their degree and type of religious orientation (from Christian to nonbelievers), their meeting styles, their pre-and post-meeting rituals, their degree of emphasis on the steps and traditions, and their approach to service work. What this means is that AA in the opening years of the twenty-first century offered more potential varieties of recovery

experiences than at any time in its history. All future efforts to summarize or categorize AA will need to address this enormous diversification of AA style and experience.

The Present and Future

Alcoholics Anonymous has become a worldwide phenomenon currently embracing more than 1.8 million members and 106,493 groups in approximately 180 countries. Fifty-five percent of AA's current groups are located outside the United States. Its literature is published in 62 languages, and as of December 2001, 31,552,413 copies of its basic text, Alcoholics Anonymous, have been sold since its initial publication. AA's success can be attributed to many things, but the unique organizational structure and the operating principles set forth in the Twelve Traditions certainly top the list of contending factors. The latter have protected AA from many of the pitfalls that proved fatal to its myriad of predecessors.

AA's greatest historical significance may rest in its having found a way to convey an experience of community in societies where the connecting tissue of authentic personal relationships seems in danger of disappearing. AA is the core of a growing phenomenon of recovery communities: people across the world who have created sober sanctuaries of mutual support, the personal meaning of which far transcends that of alcoholism recovery. These communities that defy boundaries of geography, age, gender, ethnicity, and political or religious affiliation may be one of AA's subtle but most important legacies.

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www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2003). Harold Everett Hughes. In Blocker, J. and Tyrell, I., Eds., *Alcohol and Temperance in Modern History*. Santa Barbara, CA: ABC-CLIO, 303-304. Posted at **www.williamwhitepapers.com**

Harold Everett Hughes (1922-1996)

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Harold E. Hughes, following his own recovery from alcoholism, went on to serve as Iowa's governor and United States senator and to become one of the nation's most effective advocates for federal and state support of alcoholism treatment. Hughes was born in 1922 in Ida Grove, Iowa. It was during his high school years that he discovered alcohol's ability to dissolve shyness and instill confidence. From his first contact with alcohol, he had little ability to control his drinking. He briefly attended the University of Iowa, but dropped out after his marriage to Eva Mercer.

After returning to Ida Grove following service in Italy during World War II, Hughes drinking increased, forcing his wife to file papers with the Ida County Sanity Commission to have Hughes legally committed for hospitalization as an inebriate. Hughes escaped hospitalization, but his drinking problems continued. On a day he was contemplating suicide, Hughes underwent a profound religious conversion that initiated his recovery from alcoholism and altered the course of his life. It was during this transition to sobriety (achieved in 1954) that Hughes, a truck driver by trade, accepted a position as an organizer for the Iowa Better Trucking Bureau. Switching his political affiliation from Republican to Democrat in a state dominated by Republicans, Hughes successfully served with the Iowa Commerce Commission from 1958-1962.

In a series of stunning upsets, Hughes was elected and served as Iowa=s first three-term Governor from 1962 to 1968. When his gubernatorial opponent, Evan Hultman, sought to use an old drunk driving arrest against him during the 1964 campaign, Hughes went public with the whole story of his alcoholism and his recovery. The result was a landslide victory for Hughes. As Governor, Hughes pushed through funding to establish local alcoholism treatment resources, making Iowa a model for such services at that time.

Hughes went on to serve in the United States Senate from 1969 to 1975. In 1969, he was appointed to chair the first Senate

Subcommittee on Alcoholism and Narcotics within the Labor and Public Welfare Committee. It was from this platform that Senator Hughes supported funding for alcoholism treatment programs through the Office of Economic Opportunity, and authored and championed passage of the 1970 Comprehensive Alcoholism Treatment and Prevention Act (frequently referred to as the “Hughes Act.”

Hughes served other key positions, including Chairman of the Armed Services Subcommittee on Alcoholism and Drug Abuse and was a member of the National Commission on Marijuana and Drug Abuse. He also served on the board of directors of the National Council on Alcoholism and as president of the World Council on Alcoholism.

In 1975, Hughes announced that he would not run for another term in the Senate, but would instead pursue his religious interests through the Fellowship Foundation in Washington, DC. He remained involved in alcoholism-related causes, most significantly in his role as founder and executive director of The Society of Americans for Recovery (SOAR). SOAR was never able to achieve its vision of mobilizing recovering people into a national political force. It collapsed as an organization in 1995, in part because of Hughes declining health. Harold E. Hughes died 23 October 1996.

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Citation: White, W., Godley, M. & Dennis, M. (2003) Early onset of substance abuse: Implications for student assistance programs. *Student Assistance Journal*, 16(1), 22-25. Posted at **www.williamwhitepapers.com**

Early Onset of Substance Abuse: Implications for Student Assistance Programs

By William L. White, Mark D. Godley and Michael L. Dennis

Student assistance (SA) professionals regularly encounter youth involved in a variety of high-risk behaviors — substance experimentation, high-risk sexual activity, sensation-seeking, intentional self-injury and acts of aggression toward property and people. Particularly striking to many long-tenured SA professionals is the growing co-occurrence of these behaviors and the lowering of the age at which these behaviors are seen. This article explores the early age of onset of substance use and its implications for the student assistance professional.

Age of onset trends

For fear of distorting the overall picture of adolescent drug use trends, we should start with some good news: youthful experimentation with alcohol, tobacco and other drugs (ATOD) in the United States has been relatively stable for the last few years and has even declined slightly at all grade levels as reported in the latest Monitoring the Future survey (Johnston, O'Malley, & Bachman, 2003). There are, however, three pieces of bad news from that survey. First, drug use remains almost twice as high as the 1991 low. According to this survey:

- four of five seniors consume alcohol before leaving high school,
- rates of current drinking (past 30 days) show significant alcohol exposure (20% for 8th graders,
- 35% for 10th graders and 49% for 12th graders),
- more than a quarter (27%) of high school seniors are regular smokers, and
- more than half (53%) of students consume illicit drugs before leaving high school.

Second, the perception of risk related to substance experimentation is decreasing at all grade levels while the perception of drug availability is increasing (47% of 8th graders, 76% of 10th graders, and 87% of 12th graders report easy accessibility to illicit drugs). These factors, along with perceived levels of parental and peer disapproval, are among the best predictors of future levels of drug use.

Finally, the age of onset of ATOD experimentation and regular use has

progressively declined (Dennis, Babor, Roebuck, & Donaldson, 2002). A tri-generational study of those born before 1930, between 1930 and 1949 and those born after 1949 found a progressive decline in the age of onset of regular alcohol consumption and the probability of developing an alcohol-related problem before age 25 (Stoltenberg, Hill, Mudd, Blow, & Zucker, 1999). In a study comparing the drug using behaviors of college students under 21 and those 21 or older, the younger students presented significantly lower age of onset of drinking than older students. More than half of the younger students surveyed began drinking before age 16 (Presley, Meilman, & Lyerla, 1991). Between 1965 and 1995, the rate of initiation of alcohol consumption by 12- to 17-year-olds doubled (National Institute on Drug Abuse, 1999) as the median age of onset of alcohol consumption (more than a few sips) declined to age 13 (Substance Abuse and Mental Health Services Administration, 1999). This trend crosses gender lines. The percentage of girls who began drinking between ages 10 and 14 rose from 7% in 1965 to 31% in 1995 (Substance Abuse and Mental Health Services Administration, 1999).

This lowered age of onset of drug exposure is particularly evident in populations of adolescents entering the criminal justice system and addiction treatment programs. In 1994, 38% of drug-using youth incarcerated within state-operated juvenile facilities reported onset of drug use before age 12 (19% before age 10) (U.S. Department of Justice, 1994). In the just-completed Cannabis Youth Treatment Study, more than 80% of the 600 youth admitted to the study began regular substance use between the ages of 12 and 14 (Dennis, Titus et al., 2002).

Forces influencing onset

Several factors are being examined for their potential contribution to the early onset of substance experimentation:

- decreased perception of risk among young people regarding the potential harm of ATOD use,
- decreased perception of parental and peer disapproval of ATOD use,
- decreased supervision of children and adolescents,
- intergenerational transmission of early onset male drinking, and
- targeting of young people by licit and illicit drug industries.

Understanding how new promotional forces and the diminishment of traditional inhibiting forces are interacting to lower the age of alcohol and other drug use will be crucial to implementing future strategies to reverse this trend.

Effects of early age of onset

Concern about lowered age of onset of substance use springs from several sources. First, there is a growing body of research linking early onset substance use with increased risk for subsequent substance use disorders. Information from the National Longitudinal Alcohol Epidemiological Survey revealed that the risk of adult alcohol dependence was directly related to age of onset: before age 15 (40%), age 17 (24.5%), ages 18-19 (16.5%), age 20-22 (10%). The risk of adult alcohol dependence increased an average of 9% for each decreasing year of age of onset (Grant & Dawson, 1997). In another study comparing symptoms of dependence in the past year to age of first use, it was discovered that those who started using a given substance before age 15 (when compared with those who began use after age 18) were 1.49 times as likely to have problems with tobacco (39% vs. 30%), 2.74 times as likely to have problems with alcohol (45% vs. 23%), 2.45 times as likely to have problems with marijuana (63% vs. 41%) and 2.65 times more likely to have problems with other drugs (71% vs. 53%) (Dennis, Babor et al., 2000).

In preliminary studies, early onset (before age 15) of alcohol, tobacco and other drug use also has been associated with:

- faster development of drug dependence (Kreichbaun & Zering,

2000),greater problem severity — early onset smoking is associated with heavier smoking (Chen & Millar, 1998);

- early onset drinking is associated with greater alcohol-related cognitive impairment and liver dysfunction (National Institute on Alcohol Abuse and Alcoholism, 2003; Arria, Dohey, Mezzich, Bukstein, & Van Thiel, 1995),greater problem complexity — the presence of comorbid physical disorders and psychiatric disorders and less social support for subsequent recovery (Sobell, Sobell, Cunningham, & Agrawal, 1998),
- increased risk of other life problems — lifetime risk of accidents while under the influence of alcohol (Hingston, Heeren, Jananka, & Howland, 2000) and alcohol-related violence (Hingston, Heeren, & Zakocs, 2001), and
- poor intervention outcomes via less help-seeking and greater post-intervention relapse (Keller et al., 1992; Kessler et al., 2001; Chen & Millar, 1998).

There are two views about the relationship between early onset of substance use and subsequent substance use disorders and related problems. The first is that early onset is a direct cause of such disorders and problems. The second view is that early onset substance use reflects a broader pattern of life disruption that causes both early onset and a wide range of subsequent problems (McGue, Iaconoo, Legrand, & Elkins, 2001). These theories are not mutually exclusive. We may find that early onset substance experimentation is both a cause and consequence of other problems.

Implications for SAPs

We have seen from the above review of the research that lowered age of onset of substance use is associated with the future risk, intensity, complexity and intractability of substance use disorders and related life problems. Lowered age of onset of drug use interacts with personal vulnerabilities (family history of substance problems, substance-saturated family/social environments) to generate multiple problems (for example, educational/vocational failure, depression, suicide, crime, pregnancy, infectious diseases) that compromise intervention outcomes and heighten the toll on individuals, families and communities. The early onset of substance use and related disorders also has a contagious quality in that it usually unfolds and flourishes within a peer context.

The issue of lowered age of onset of substance use has particular relevance to student assistance programs. The precocious onset of substance use in children signals vulnerability for the development of other problems (conduct disorder, attention disorders and affective disorders, among others) and behaviors that pose risks to the individual child and others. These other problems have a complex interaction with substance use and can precede, co-occur, or follow substance initiation. Intervening in these other problems and behaviors constitutes a crucial prevention or early intervention strategy for substance-related problems, just as proactive intervention into early substance use serves the same functions for these other problems. “Silo programs” that target a single problem or risk behavior must eventually give way to more integrated programs that focus on promoting the global health and development of these children.

SA programs can play an important role in lowering the short- and long-term risks to individuals, families and communities by postponing substance use initiation as long as possible, and by recognizing developmental windows of vulnerability and opportunity in the transitions from early drug experimentation to chronic drug dependence. More specifically, SAPs can:

- enhance protective factors (pro-social values, skills and family and peer relationships) prior to the developmental period (ages 9 to12) of

greatest vulnerability for drug use initiation and related problems;

- deliver focused support to children at risk for the development of substance use problems (family history of alcohol and other drug problems, parental detachment, access to alcohol and/or other drugs at home, academic struggle/failure, emotional distress, involvement in drug-oriented peer cultures, behavioral problems, involvement in criminal justice system, and atypical drug sequencing (use of marijuana before alcohol and use of other illicit drugs before marijuana) (National Institute on Alcohol Abuse and Alcoholism, 2003; Kandel, Johnson, & Bird, 1999; Mackesy-Amiti, Fendrich, & Goldstein, 1997));
- prevent or slow the movement from initial to regular drug use;
- intervene before the transition from single to multiple drug experimentation;
- interrupt the progression from regular drug use to drug-related problems and drug dependence;
- prevent an expanded repertoire of high risk, health-threatening behaviors, for example, unprotected sex with multiple partners, high risk behavior in vehicles, crime, and violence; and
- intervene with those experiencing substance use disorders to restore personal health and diminish problem contagion within the school and community.

SA professionals can help communities examine the national and local changes that are contributing to lowered age of onset of ATOD use (and other risk behaviors) and find ways to sustain and strengthen those strategies that reduce these problems. SA professionals also can play an active part in shaping community norms and standards related to ATOD use, confronting and countering the targeting of young people by licit and illicit drug industries, and advocating a full continuum of community-based youth-oriented prevention, early intervention, treatment and post-treatment recovery support services.

Early ATOD exposure, whether as a consequence or cause of other problems, seems to be a visible indicator for inclusion in a growing group of individuals who exhibit early and prolonged physical, social, and educational/vocational disability. This group goes on to consume massive quantities of human services that do little to alter the quality of their lives or their level of functioning. Early intervention is the key to preventing this pattern. Research is showing that the earlier the age of intervention into such problem constellations, the greater the long-term prognosis for problem resolution, even when that resolution requires multiple interventions over time (Dennis, Scott, & Funk, under review). Investment in SA programs is an effective strategy for positively altering the developmental trajectory of children at high risk for life-shortening and life-impairing problems.

Young people are developing life-impairing and life-threatening problems with alcohol, tobacco and other drugs who would not have developed these problems if their initial exposure to these substances could have been postponed (Chou & Pickering, 1992). ATOD-related problems resulting from early age of onset are among the most preventable causes of death and disability. For more than 150 years (1820 to 1970), this country successfully postponed significant (defined as frequent, heavy or binge use), unsupervised (outside the context of family/religious rituals) alcohol and other drug exposure until after puberty. In the past three decades, ATOD experimentation has shifted from a symbolic rite of passage from late adolescence into adulthood to a rite of passage from childhood into adolescence. It is time this shift was recognized as the most clinically and socially significant drug trend of the past century (White, 1999). SA professionals and other activists must call upon America and its local communities to examine the sources and solutions to early onset ATOD use. This trend must be reversed.

Acknowledgment: This work was supported by CSAT contract no. 270-97-7022. The opinions are those of the authors and do not reflect official positions of the government.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W., & McGovern, T. (2003). Treating alcohol problems: A future perspective. *Alcoholism Treatment Quarterly*, 3/4, 233-239. Posted at **www.williamwhitepapers.com**

Treating Alcohol Problems: A Future Perspective

William L. White, MA and Thomas F. McGovern, EdD

Abstract

In this closing article commemorating the twentieth anniversary of the publication of Alcoholism Treatment Quarterly (ATQ), the editors offer their own thoughts about the future treatment of alcohol problems in the United States. The review includes twenty-two predictions that topically span the organization and staffing of the treatment field, the central ideas that undergird the field, and the future of clinical technologies used to treat alcohol problems.

Key Words: Future, trends, client characteristics, treatment technology, aging of workforce

Introduction

The authors of the articles in this special issue commemorating the 20th volume of *ATQ* hint at many things to come in the future treatment of alcohol problems. They envision a treatment field that is more ethically centered, evidence based, recovery focused, community linked and more clinically nuanced for those with special characteristics and needs. In this final article, the editors of this special issue offer our own thoughts about the future treatment of alcohol problems in the United States. This review includes predictions that topically span the organization and staffing of the treatment field, the central ideas that undergird the field, and the future of clinical technologies used to treat alcohol problems. It is our hope that this list will stir discussion about the most critical issues in the future treatment of alcohol problems.

Infrastructure and Cultural Context

Prediction 1: The federal/state/local partnership created by the Comprehensive Alcoholism Prevention and Treatment Act of 1970 (known as the Hughes Act) will be challenged by the growing restigmatization, demedicalization and recriminalization of severe alcohol and other drug problems. We believe this partnership and the treatment system it sustains will survive due to support from new and renewed grassroots recovery advocacy groups and increased responsiveness of local treatment programs to a broad spectrum of alcohol-related problems.

Prediction 2: The federal investment in an alcohol problems research infrastructure will reap significant rewards in the coming decades. For example, we anticipate that new understandings of the neurobiology of alcohol dependence will reap rewards in terms of new clinical tools for assessment and treatment, the most significant of which may be the ability to distinguish alcohol problems of biological and non-biological origin and the introduction of fundamentally new pharmacological adjuncts to treatment.

Organization

Prediction 3: The integration of the treatment of alcohol and other drug problems–arguably one of the major professional achievements or (according to some) the worst mistake of the past 25 years--will progress in the next decades with a full integration of the treatment of nicotine addiction alongside the treatment of other drug addictions. The over-extension of the concept of addiction to other problem areas will spur a redefinition of the boundaries of the field, distinguishing the use of *addiction* as a medical concept versus the personal use of the concept of *addiction* as an organizing metaphor for behavioral change.

Prediction 4: The categorical segregation of the treatment of alcohol problems will be severely challenged in the next two decades as alcohol treatment programs are absorbed into larger umbrellas of "behavioral health" and "human services." While such integration promises a more consumer-friendly service process and a better stewardship of community resources, our fear is that the field of alcoholism treatment could disappear while the illusion of its presence continues.

Problem Definition

Prediction 5: Multi- pathway models of understanding and intervening in alcohol problems will replace more traditional, single-pathway models. These prevailing models will detail how alcohol problems spring from multiple etiological pathways, unfold in diverse patterns with varying courses/outcomes, and are resolved through diverse clinical interventions and innumerable pathways and styles of long term recovery. This conceptual shift will require that treatment agencies shift from offering a "program" to offering a wide menu of services that are uniquely combined and sequenced based on the needs and readiness for change of each client/family.

Prediction 6: The next two decades will witness attempts to integrate the emerging public health and medical/clinical models of understanding and responding to alcohol problems. We feel the integration of the former, which places emphasis on the economic, social and political ecology of alcohol problems, and the latter, which emphasizes the role of the individual as the source and solution to alcohol problems, has great potential.

Changing Characteristics of Treatment Consumers

Prediction 7: Differences between community and clinical populations will widen with the multiple problem client/family (greater problem severity and psychiatric co-morbidity and fewer recovery assets) becoming the norm within publicly funded treatment programs. This will create a growing dichotomy between individuals who can resolve alcohol problems with recovery self-management tools (e.g., manuals and online recovery support services) or brief professional intervention versus those who will require multi-agency models of sustained recovery management. The latter clients will require a broader menu of services (far beyond acute models of detoxification and symptom stabilization) delivered over a much longer period of time.

Prediction 8: Escalating life expectancies and the demographic aging of the "war babies" will spark growing concern about the problem of late-onset alcohol problems. We anticipate that the prevention and treatment of such problems will become a major specialty within the alcohol problems field.

The Professionalization of Treatment Providers

Prediction 9: The recognition of addiction medicine as a recognized specialty will continue, but will be offset by greater involvement of primary physicians, physician assistants, and nurse practitioners in the treatment of alcohol problems. The further professionalization of addiction medicine will be hampered by the recent restigmatization and demedicalization of alcohol problems and the resulting marginal status associated with this arena of medical practice.

Prediction 10: The continued professionalization of the role of the addiction counselor (e.g., the licensure movement) will be balanced by new roles (recovery coaches, recovery support specialists) that will bring greater numbers of recovering people back into the field. Some will interpret this latter trend as a de-professionalization of the field while others will view this as a renewal process and a needed re-connection of treatment and recovery.

Prediction 11: Professional roles in the field, dominated by men when the first issue of ATQ was published, will be increasingly filled by women. This feminization of the field will add momentum to address the special needs of women impacted by alcohol problems.

Treatment Technology

Prediction 12: The organizing mantra of the next decade will be the call to bridge the gap between clinical research and clinical practice in the resolution of alcohol problems. The failure to achieve this goal could threaten the very future of the field; the achievement of this goal could move treatment from the status of a folk art to a science-guided endeavor. Some of the most promising applications include new identification and engagement technologies, a new generation of global assessment and service planning instruments; new pharmacological adjuncts to treatment; evidence-based, manual-guided therapies; and sustained recovery management protocols.

Prediction 13: The next decade will witness the widespread application of disease (recovery) management technologies from primary medicine to the treatment of severe and persistent alcohol problems. We believe that the shift from an exclusively acute model of intervention to a continuum of interventions that include the option for sustained recovery management will mark one of the most significant technical advancements in the history of the field. This breakthrough marks the marriage of the relapse prevention technologies of the alcohol field with techniques used in primary medicine to manage chronic disorders like diabetes, asthma, and hypertension.

Prediction 14: Research findings will compare and contrast explicitly religious and spiritual frameworks of recovery from explicitly secular frameworks. Although hoped-for treatment matching effects have not been robust in existing studies, there may be matching effects related to these broader frameworks.

Prediction 15: There will be a movement to push the breakthroughs in knowledge about special populations of clients from the enclave of the demonstration project to the mainstream of the field. It is time these breakthroughs in understanding and technique were moved from the status of loosely attached appendages to the field to the very heart of the field, e.g., front line clinical practice in non-specialty programs.

Professional Ethics

Prediction 16: There will be a significant movement in the next decade to get the treatment field ethically re-centered. This movement will include developing new ethical decision-making models, upgrading organization codes of professional practice, and advanced training to enhance ethical sensitivities and ethical decision-making

skills. A major focus of this work will be on the development of ethical standards related to the field's business practices–an arena we view as one of continued vulnerability for the field.

Prediction 17: New roles that focus on harm reduction, pre-treatment/engagement, and sustained recovery support will call for a re-evaluation of traditional definitions of appropriateness related to ethical conduct, particularly those governing relationship boundaries. This will emerge as an area of intense debate within the field and call for heightened supervisory support for persons filling these roles.

Recovery and Community

Prediction 18: The treatment field will face in the next decade what it has never faced in its history: a strong consumer/constituency movement. This new recovery advocacy movement will demand inclusion of recovering people and their families in the planning and evaluation of treatment services. This movement will demand lower thresholds of engagement, higher thresholds of extrusion, and a greater focus on building long term recovery support services for individuals and families.

Prediction 19: The locus of treatment will expand beyond the institutional/office environment to the natural environment of each client. "Systems interface" will become the rule rather than the exception as alcohol treatment agencies enter into an increasing number of service delivery partnerships with public health, mental health, child welfare, criminal justice, educational, occupational and welfare institutions. Treatment and recovery support services will be offered in a wider variety of settings–health care clinics, churches, community centers–but they will also be much more likely to be delivered within neighborhoods and homes. Work with client's enmeshed in drug/criminal cultures will focus on guiding the client into relationship with an alternative culture of recovery and organizing such cultures where none exist.

Prediction 20: There will be increased demands for the field to shift its research focus from one of pathology to one of resilience and recovery. More specifically, there will be calls to generate new service technologies based, not on studies of the problem, but on studies of the myriad solutions that already exist in the lives of individuals and families in communities across America. There will be calls to plot the long term pathways, stages and styles of recovery and to delineate these findings across such factors as gender, age, ethnicity, and clinical profiles. Advocacy for this resilience and recovery research agenda will generate parallel calls for strengths-based models of assessment and intervention.

Prediction 21: The growing "varieties of recovery experience" will continue to manifest themselves within the growing diversification of mutual aid structures. As these structures become more geographically accessible, the communities of recovery with whom treatment programs will be collaborating will be greater in number and more diverse than anyone could have anticipated, confirming in local communities across the country A.A. cofounder Bill Wilson's 1944 observation that "the roads to recovery are many."

Achilles Heel: The Aging of the Field

Prediction 22: The rapidly approaching loss of long-tenured clinical and administrative leaders will constitute one of the most significant challenge to the future integrity and existence of the field. If major efforts are not implemented to address the issues of leadership development and leadership succession, much of the field's history, core values and technical knowledge will be lost, and the field will be vulnerable to colonization by more powerful forces within its operating environment. The mantle of leadership of the alcoholism treatment field is about to be passed: Will there be a new generation of prepared leaders there to accept it?

A Closing Thought

If there is a legacy of this past twenty years it is most fittingly the fact that there are hundreds of thousands of individuals and families in recovery today whose lives were touched by professionally-directed treatment services. For the past twenty years, ATQ has detailed the interventions that have made such transformations possible. It is hoped that twenty years from now, *ATQ* will be again celebrating the reality and methods of such recoveries.



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Citation: White, W. and Webber, R. (2003). The future of drug use in America. *Counselor*, 4(4):18-20. Posted at **www.williamwhitepapers.com**

The Future of Drug Use in America

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"We don't like their sound, and guitar music is on the way out." --Decca Recording Co., rejecting the Beatles, 1962.

Making predictions is a risky business. Many past predictions stand as monuments of their creators' foolishness. Time may also cast us among these defamed guessers, but after describing in our last article how history can be used to interpret and anticipate drug trends, we couldn't resist offering some informed speculations about what lies ahead.

We wish to begin and end this article by noting the potential of what could be the most important milestone in the history of mood alternation. Scientists have known for almost half a century that stimulation of certain parts of the human brain can produce feelings of intense euphoria similar to those reported by users of cocaine, alcohol and heroin. Creating such feelings through direct brain stimulation is, to date, a complex, expensive and risky process, but a day may come when new technologies are available to self-stimulate these reward pathways without mediation by drugs. We will later speculate on the potential meaning of such a technological revolution.

In the meantime, join us in thinking about the about the future of drug use. Here are our top predictions for the next twenty-five years.

Historical Continuity In the arena of psychoactive drug consumption, much of what has been will be. We will continue to have celebrated drugs (alcohol and caffeine) and instrumental (prescription) drugs that form the core drug menu for most Americans. Preferences beyond these core choices will continue to evolve and recycle. The shift of nicotine from a celebrated drug to a (barely) tolerated drug will continue to accelerate, and battles over the cultural, medical and legal status of cannabis will intensify. The focus on tobacco and illicit drugs will continue to mask changes occurring in the consumption of alcohol and prescribed psychoactive drugs. We will continue individually and collectively to go through cycles of introspection, stimulation and anesthesia, and our evolving appetite in drugs will mirror our desire for these experiences.

Short Term Predictions There are several near-future predictions we would offer: a) stimulant use will move from its past

cyclical pattern to an endemic pattern, b) communities experiencing high levels of cocaine and methamphetamine dependence will witness a rise in alcoholism, sedativism, and narcotic addiction, c) alcohol, cannabis, sedative, and narcotic use will rise in the larger society as a personal side effect of geopolitical and economic distress, d) drug choices will become less demarcated by gender (as gender role socialization dissipates), but will become more demarcated by age, education and social class, e) youthful binge drinking will increase due to decreased supervision, increased leisure time (4-day school week) and the cumulative effects of alcohol advertising.

Early Onset of Drug Use The declining age of onset of regular alcohol, tobacco and other drug use will emerge as a major public health and political issue in the next decade. This issue will intensify as research confirms the role of early age of onset in the risk for adult substance use disorders, the speed of progression and severity of such disorders, and the compromised prognosis for long-term recovery. Investigations into the source of this change will spawn new allegations of sustained targeting of youth by the alcohol, tobacco and pharmaceutical industries.

Drug Use as a Rite of Passage Experimentation with alcohol, tobacco and other drugs will move from a rite of passage from adolescence into adulthood to a rite of passage from childhood into adolescence. Adolescent drug use will be greatly influenced by the culturally defined duration of adolescence and the changing value of drug use as a symbolic rite of passage into adulthood. Other rites of passage (sexual intimacy, pre-marital cohabitation, and full time employment) will come to replace alcohol and other drug use as symbols of family emancipation and the acquisition of adult status.

Late Onset Drug Use Increased life expectancies and shortened work careers will influence the development and popularity of drugs that simultaneously blunt physical and emotional discomfort and stimulate personal, interpersonal and spiritual growth. Psychoactive drug use by those over age 50 will emerge as a significant social issue. By the year 2050, socially approved periods of tranquilization and euphoria will be widely available as a therapeutic and recreational experience and as a medium of personal development and spiritual/religious enlightenment. Paradoxical effects of late onset drug use and greater cumulative lifetime doses will require rethinking the effects of many psychoactive drugs. The treatment of late onset substance-related problems will grow as a specialty within the substance use field.

Globalization of Drug Trends Increased contact between all of the countries of the world will lead to: a) an enlargement of America's psychoactive drug menu, b) the globalization of drug tastes, and c) a breakdown in drug-related social policies historically rooted within unique political, economic and religious contexts. Knowledge of the global diversity of psychoactive drug use and alternative drug control policies will weaken the American dichotomy of "good" drugs and "bad" drugs and exert pressure for changes in American drug policies.

America, The Drug Pusher. The massive exportation and promotion of American tobacco products to Asian, African, and Eastern European countries (to offset the decline in our own consumption) will create great harm to America's world image and create a political backlash of unprecedented proportions when tobacco-related diseases and deaths reach epidemic proportions in these countries. America will be accused of being the most unconscionable drug pusher in the world–a predatory nation that for the sake of financial gain promoted tobacco use worldwide with full knowledge of its devastating long-term effects.

Technology Innovation New technologies will accelerate the introduction

of more potent psychoactive drugs, new methods of drug administration, and new medications designed to reverse the acute and chronic untoward effects of particular drugs, e.g., the long-sought amythestic agent (sober pill) for rapid reversal of alcohol intoxication. New methods of drug administration will allow substances currently administered only through smoking or ingestion (e.g., cannabis) to be administered by vapor, decreasing respiratory illness but greatly increasing the potential for addiction.

Safer Intoxicants There will be a growing call for the development of safer intoxicants. New generations of psychoactive drugs will force a redefinition of our understanding of who is vulnerable to drug addiction from one of selective vulnerability to universal vulnerability. These new drugs will challenge traditional definitions of addiction by targeting reward centers in the brain (producing euphoria) without tissue tolerance, withdrawal, or prolonged untoward effects. Such products will become highly celebrated drugs for those who can afford them.

From Pain and Pleasure to Performance New drugs that enhance and expand human performance and experience will mark a third pharmacological revolution (the earlier eras having been marked by relief from physical and emotional pain and the quest for pleasure).

Drugs and Social Control The same new drugs that bring us the potential to enhance performance will also be used as mechanisms of behavioral control. The use of mandatory chemical restraints will come into increasing vogue in the next century as a cost-effective alternative to incarceration. There will be new long-acting drugs of control and new methods of administration (e.g., surgical implants) that do not require voluntary self-administration. Both the soma of Huxley's *Brave New World* and the Moksha medicine of Huxley's utopian *Island* will be technically possible in the next century. Human rights issues involved in the use of such substances will stir great debate.

Planned Synergism A major trend of the next century will be the planned, simultaneous administration of two or more drugs to achieve an effect different than and greater than their independent effects. Such strategic synergism challenges centuries of knowledge based on studying the effects of each drug in isolation and poses the potential of two drugs, which in isolation have a low potential for misuse, having a high potential for misuse when combined. Such planned synergism will challenge our current schema for legally classifying drugs.

Designer Drug Disaster There will be a major designer drug disaster during the first half of the 21st century. Minor changes in the molecular structure of a drug can provoke devastatingly different effects. A dramatic illustration of this principle occurred during the illicit manufacture of MPPP-an analogue (chemical cousin) of the synthetic narcotic, meperidine (Demerol). A mis-synthesized analogue (the neurotoxin MPTP) of MPPP (sold illicitly as "China White") induced a severe Parkinson's-like condition in those who injected it. The authors' worst fear is a chemical time bomb planted in the brain of thousands: the introduction of a new designer drug whose desirable short term effects (which generate widespread experimentation) mask devastating long term consequences that only appear years after initial drug exposure. This same effect might also result from accidental or planned synergism.

Drugs and Religion The effects of new generations of drugs will be so profound in their alteration of human consciousness that new religions and social movements will spring up around their use. These movements will spawn a counter-movement via a growing number of American subcultures that adhere to radical abstinence as a personal lifestyle or political choice.

Drugs as Weapons Intoxicants have a long history as weapons of interpersonal, political and economic exploitation and will

continue to be used for this purpose in the coming century. New psychoactive agents will find increased use in the immobilization of military and civilian populations. Psychoactive drugs will be increasingly used as terrorist and anti-terrorist weapons via the disablement of targeted individuals and groups.

Beyond Drugs Technologies to produce direct stimulation of the reward circuits of the brain will render drugs obsolete by the end of the 21st century. New non-psychoactive drugs or other forms of neurochemical stimulation will be used to trigger the body's production of psychoactive enzymes. Through such technological breakthroughs, the psychoactive substance would come from within rather than from outside the body. This will trigger considerable social debate about whether the ultimate authority to regulate human neurochemistry is the right and responsibility of the individual or resides with the state.

These are some of our predictions. We'd love to hear yours. Send us your predictions by email or via a letter to the editor of Counselor.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2003). Hazelden Foundation. In Blocker, J. and Tyrell, I., Eds. *Alcohol and Temperance in Modern History*. Santa Barbara , CA: ABC-CLIO, pp. 290-291.Posted at **www.williamwhitepapers.com**

Hazelden Foundation

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The Hazelden Foundation is a Minnesota-based, non-profit organization whose mission is to "help build recovery in the lives of individuals, families and communities affected by alcoholism, drug dependency and related diseases." For more than fifty years, Hazelden has been one of the best known providers of addiction treatment services in the United States, as well as the largest publisher and distributor of addiction- and recovery-related publications. Since its opening in 1949, Hazelden has treated more than 200,000 chemically dependent individuals and their families from all fifty states and every continent, and has distributed more than 50 million pieces of addiction/recovery-related literature.

Hazelden was conceived during a period in which alcoholics languished in the "drunk tanks" of city and county jails, and in the "snake pits" of aging state psychiatric hospitals. Few resources existed for any alcoholic, either rich or poor. The first Hazelden treatment facility opened in Center City, Minnesota, following extended discussions about the need for an alcoholism treatment facility for priests and other professionals. Initial financial support came from the Catholic Diocese and contributions from local businesses. The expectations placed on its first residents were exceedingly simple: make your bed, conduct yourself as a gentlemen, attend the daily lectures on the Twelve Steps of Alcoholics Anonymous, and talk with one another. Hazelden's treatment philosophy was able to expand and evolve, due in great part to the financial resources of Emmet, Patrick and Lawrence Butler, whose combined largesse sustained Hazelden through its early years. During the 1950s, the collaboration between Hazelden and two other Minnesota alcoholism treatment facilities, Pioneer House and Willmar State Hospital, created a unique approach (the "Minnesota Model") that exerted an enormous influence on the evolution of addiction treatment in the second half of the twentieth century. This model, as articulated by its early proponents—Dr. Nelson Bradley, Dr. Dan Anderson, Reverend John Keller, and Reverend Gordon Grimm--defined alcoholism as a primary, progressive disease whose resolution required lifelong abstinence; extolled the importance of treating the alcoholic and addict with dignity and respect; emphasized the importance of a mutually supportive treatment milieu; utilized a multi-disciplinary treatment team and a full continuum of

services; and integrated the steps and social support of Alcoholics Anonymous during and following treatment.

Over the years, Hazelden grew beyond its humble beginnings as a small, obscure treatment facility by adding an array of programs and services. These expansions began with the opening of a halfway house for men (Fellowship Club) in 1953 and a treatment facility for women (Dia Linn) in 1956. Services continued to expand on the Center City campus under the leadership of Dr. Dan Anderson both in terms of residential treatment capacity and in the variety of new services offered, including a formal family program and outpatient services. Hazelden later expanded beyond Minnesota by opening treatment centers in Florida, New York, Texas and Illinois.

In 1954, Hazelden entered the world of publishing when it bought the rights to *Twenty-Four Hours a Day*, a recovery meditation book that would go on to sell more than seven million copies. Hazelden went on to publish materials ranging from scholarly texts such as *Not-God: A History of Alcoholics Anonymous* by Ernest Kurtz, to popular self-help books such as Melanie Beattie's *Codependent No More*. Hazelden publishing grew from this single title to a division that today distributes more than three and one half million books, pamphlets, videos, and recovery celebration items per year.

Hazelden's commitment to provide public and professional education on addiction and related disorders has also led it into the arenas of training and consultation. Hazelden offers a chemical dependency counselor certificate training program as well as a master's degree and post-graduate certificate in addiction counseling. The Counselor Training Program in Center City has graduated more than 500 individuals from thirty-two countries, and more than 100 individuals have graduated from Hazelden's Counselor Training Program in Europe. Hazelden's Pastoral Training Program and its Professional in Residence and Physician in Residence programs have also trained more than 2,500 addiction treatment providers from all over the United States and more than fifty other countries.

Hazelden was the primary instrument through which the Minnesota model of chemical dependency treatment spread throughout the United States and abroad. This model was spread by persons who had been treated at Hazelden, by graduates from Hazelden's training programs, by the thousands of addiction professionals from more than fifty countries who have visited Hazelden, and by the large body of professional literature and treatment aids published and distributed by the Hazelden Publishing and Educational Services Division. Hazelden staff also served as consultants on the development of alcoholism treatment programs in other countries. Another Hazelden service milestone was the 1993 opening of the Hazelden-Pittman Archives, a repository of books, manuscripts and artifacts related to the history of addiction treatment and recovery in America.

Today (2002), Hazelden's 400 clinical staff treat more than 9,000 individuals and their families each year within its treatment centers. The philosophy undergirding these services has shifted from one that focused on providing treatment services to a mission of providing recovery services. Where the former focused on initiating recovery from addiction, the latter offers a wide range of services that can support individuals and families through the long-term developmental stages of recovery. Symbolizing this broadened vision was the opening of Hazelden's Renewal Center. This center provides relapse prevention training, as well as a wide variety of retreats aimed at strengthening sobriety and enhancing the emotional, relational and spiritual growth of individuals and families in recovery from alcoholism and other addictions. Hazelden has also expanded its mission to address recovery support services for other chronic and related diseases. To that end, Hazelden provides mental health services for recovering people who experiences such co-occurring disorders as depression, anxiety, post-traumatic stress disorder, gambling, and eating disorders.

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Citation: White, W. (2004). History of drug problems and drug policies in America. In R. Coombs (Ed.), *Addiction counseling review: Preparing for comprehensive certification exams*. Lahaska Press, pp.81-104. Posted at **www.williamwhitepapers.com**

History of Drug Policy, Treatment, and Recovery

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Introduction

The purpose of this chapter is to offer you a brief overview of the history of: 1) alcohol and drug-related problems, 2) recovery mutual aid societies, 3) addiction treatment, and 4) addiction-related laws and social policies in America. The histories of mutual aid and treatment, unless otherwise noted, are drawn from *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. The history of alcohol, tobacco and other drug-related laws and social policies is drawn primarily from the published works of Drs. David Musto and David Courtwright.

History is about chronology and context: it is about how events influence one another to shape the present and future. The importance of studying the roots of our field is reflected in the words of Lily Tomlin who once noted, “Maybe if we listened, history wouldn’t have to keep repeating itself.”

When did alcohol and other drug problems begin in the United States?

Alcohol usage was pervasive in colonial America. Men, women and children consumed alcoholic beverages every day and throughout the day. The tavern was the center of colonial life. America’s first colleges had breweries on campus for the convenience of faculty and students. In spite of the ever-presence of alcohol, drunken comportment was highly stigmatized, and there was no recognition of alcoholism as we know it today. Isolated problems of chronic drunkenness were viewed as a moral or criminal matter rather than a medical or public health problem.

Dramatic changes in drinking patterns following the Revolutionary War changed the conception of alcohol from the “Good Creature of God” to “Demon Rum.” Between 1780 and 1830, annual per capita alcohol consumption in America rose from 2 ½ gallons

to more than 7 gallons, and drinking preferences shifted from fermented beverages such as cider and beer to rum and whiskey (Rorabaugh, 1979). Rising alcohol-related problems during this period led to the "discovery of addiction" (Levine, 1978).

Alcohol was not the only drug generating public concern in the nineteenth century. Increased consumption of opium, morphine, cocaine, chloral, ether and chloroform via medical treatment or liberal self-treatment with patent medicines generated new patterns of addiction and growing civic alarm. The dominant profile of the opiate addict during this period was an educated, affluent, middle-aged white woman (particularly in the South).

New technologies that heightened drug potency, expanded the methods of drug ingestion, increased drug availability and unleashed unprecedented promotional forces played a significant role in the rise of these new patterns of addiction.

Figure 1: Technology and the Rise of American Drug Problems

Technological Innovation	Significance
Increased Distillation	Increased Alcohol Addiction (shift from fermented beverages to distilled spirits)
Isolation of Plant Alkaloids	Increased Morphine & Cocaine Addiction
Hypodermic Syringe	Increased Opiate & Cocaine Addiction
Newspaper Advertising	Promotion of Alcohol-, Opiate-, and Cocaine-based Patent Medicines
The Wooden Match; Cigarette Rolling Machine	Increased Nicotine Addiction

In 1800, America had no conception of addiction; in 1900, she had witnessed a growing psychoactive drug menu, experienced her first anti-drug campaigns, passed numerous local and state anti-drug laws, and generated a significant body of literature about addiction—all of which were about to culminate in the prohibition of alcohol, tobacco and the non-medical use of opiates and cocaine.

When did the first medical conceptions and responses to addiction begin?

America's revolution in consciousness about alcohol was engineered by her most prominent social activist, her most eminent physician, and a leading clergyman. In 1774, Anthony Benezet, a Quaker social reformer, published a stinging indictment of alcohol entitled *Mighty Destroyer Displayed.* He christened alcohol a "bewitching poison and spoke of "unhappy dram drinkers . . . bound in slavery" who had lost voluntary control of

their decision to drink or not drink. Dr. Benjamin Rush followed Benezet's writings with a series of pamphlets culminating in his 1784 *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body.* Rush suggested that chronic drunkenness was a "disease induced by a vice," described the progressive nature and medical consequences of this disease, and suggested that chronic drunkenness be viewed as a medical rather than a moral problem. Perhaps most importantly, Rush argued that it was the responsibility of physicians to treat this disorder, and suggested several methods (ranging from religious conversion to aversive conditioning) through which chronic drunkards could be cured. By 1790, Rush was calling for the creation of a special hospital for inebriates (a "Sober House"). The third influence on America's changing conception of alcohol and chronic drunkenness was the Reverend Lyman Beecher who in 1825 delivered his widely read *Six Sermons on the Nature, Occasion, Signs, and Remedy of Intemperance*. Beecher spoke of the drunkard as being "addicted to sin," characterized intemperance as an accelerating disease, meticulously detailed its early stages, and argued that complete and enduring abstinence was the only method of prevention and cure.

By the late 1820s, the American Temperance Movement was underway, and there was a growing trend toward the medicalization of alcohol and other drug problems. Between 1828-1832 two prominent medical directors of state insane asylums—Drs. Eli Todd and Samuel Woodward—added their support for the creation of special institutions for the care of the inebriate. In the transition from the 18th to the 19th century, a vanguard of American physicians and social reformers redefined drunkenness as a medical problem, encouraged physicians to treat inebriety in their medical practice, and called for the creation of specialized institutions. Inherent in this shift were the core elements of an addiction disease concept: hereditary predisposition, drug toxicity, morbid appetite (craving), pharmacological tolerance and progression, loss of volitional control of drug intake, and the pathophysiology of chronic alcohol, opiate, or cocaine consumption. This early movement reached fruition in the work of Swedish physician Magnus Huss, who in 1849 introduced the term "alcoholism" to characterize the a cluster of symptoms "formed in such a particular way that they merit being designated and described as a definite disease." While many new terms were suggested for this phenomenon, *inebriety* was the preferred term whose meaning is analogous to the term addiction. Texts of the day included chapters on alcohol inebriety, opium inebriety, cocaine inebriety, and inebriety from coffee and tea. The term *alcoholism,* whose use is presently diminishing, did not achieve professional or cultural prominence until the early decades of the twentieth century (White, 2002b).

When did addiction treatment begin in the United States and what types of treatment were first available?

By the 1830s, the growing Temperance Movement was experimenting with "rescue work" with inebriates. Several temperance societies concluded that inebriates needed more than pledge-signing and attendance at temperance meetings to sustain sobriety. To buttress such sobriety, inebriate homes were created that viewed recovery from

alcoholism as a process of moral reformation and immersion in sober fellowship. The first of these homes—the Washingtonian Homes in Boston and Chicago—opened in 1857 and 1863. The inebriate homes utilized short, voluntary stays followed by affiliation with local recovery support groups.

The call for specialized medical facilities resulted in another institution—the medically-directed inebriate asylum that relied on legal coercion (multi-year legal commitments) and emphasized physical and psychological methods of treatment (drug therapies, hydrotherapy, hypnotherapy). The first of these facilities—the New York State Inebriate Asylum—opened in 1864 under the leadership of Dr. Joseph Edward Turner.

In 1870, the leaders of several inebriate homes and asylums met in New York City to found the American Association for the Cure of Inebriety—the first professional association of addiction treatment providers. In 1876, the Association began publishing the *Quarterly Journal of Inebriety,* the first addiction-themed specialty journal. It was edited by Dr. T.D. Crothers for the life of its publication (1876-1914).

Figure 2: Bylaws of the American Association for the Study and Cure of Inebriety (1870)
1. Intemperance is a disease. *2. It is curable in the same sense that other diseases are.* *3. Its primary cause is a constitutional susceptibility to the alcoholic impression.* *4. This constitutional tendency may be either inherited or acquired.*

As inebriate homes and asylums achieved greater visibility, they faced competition from several sources, including private, proprietary (profit-making) addiction cure institutes. The most famous of these, the Keeley Institute, was founded in 1879 with the proclamation by Dr. Leslie Keeley that "Drunkenness is a disease and I can cure it." Dr. Keeley went on to franchise more than 120 Keeley Institutes that used his Double Bi-Chloride of Gold Cures for Drunkenness and the Opium and Tobacco Habits.

There were also bottled home cures for the "alcohol, tobacco and drug habits." These aggressively promoted products were the brainchild of the addiction cure institutes and the same patent medicine industry that was doping the nation. These alleged addiction cures continued until an exposé in 1905 revealed that most of these products contained high dosages of morphine, cocaine, alcohol and cannabis. The morphine addiction cures that promised consumers a product containing no narcotic or narcotic substitute nearly all contained high dosages of morphine.

Institutional intervention into chronic alcoholism was also provided by religiously oriented urban rescue missions and rural inebriate colonies. The former were pioneered by Jerry McAuley who opened the Water Street Mission in 1872 after his own religiously inspired recovery from alcoholism. Such rescue work with late-stage alcoholics was later institutionalized within the programs of the Salvation Army.

The final institution that bore an increasing brunt of responsibility for the care of the chronic inebriate was the urban city hospital. Bellevue Hospital in New York City opened an inebriate ward in 1879 and saw its alcoholism admissions increase from 4,190 in 1895 to more than 11,000 in 1910.

Figure 3: Professionalized Treatment of Addiction in the Nineteenth Century

Treatment/Care of Inebriates	Representative institution/product	Founding date
Inebriate Homes	Washingtonian Home	
	-Boston	1857
	-Chicago	1863
	Martha Washington Home (first women's facility)	1869
Inebriate Asylums	New York State Inebriate Asylum	1864
For-Profit Addiction Cure Institutes	Keeley Institutes	1879
	Gatlin Institutes	
	Neal Institutes	
Bottled/Boxed Addiction Cures	Hay-Litchfield Antidote	1868
	Knight's Tonic for Inebriates	1870s
	Collin's Painless Opium Antidote	1880s
Urban Missions & Inebriate Colonies	Water Street Mission	1872
	Keswick Colony of Mercy	1897
City Hospital Inebriate Wards	Bellevue Hospital—New York City	1879

It should be noted that nearly all of these institutions—particularly the inebriate asylums and addiction cure institutes—treated addictions to all drug addictions, including cocaine addiction. There were facilities like Dr. Jansen Mattison's Brooklyn Home for Habitues (opened in 1891) which specialized in the treatment or morphine and cocaine addiction.

What happened to the hundreds of treatment programs that existed in the 19th century?

Between 1900 and 1920 most of the addiction treatment institutions that had been founded in the second half of the nineteenth century closed. This virtual collapse of America's first network of addiction treatment programs was caused by multiple factors: 1) exposés of ethical abuses related to the field's business and clinical practices, 2) ideological schisms within the field, 3) absence of scientific studies validating the effectiveness of treatment, 4) loss of the field's leadership via aging and death, 5) unexpected economic downturns that deprived the field of philanthropic and governmental support, and 6) growing cultural pessimism about the prospects of permanent recovery from alcohol and other drug problems.

The rise of therapeutic pessimism led to a bold new vision for resolving these problems: let those currently addicted to alcohol and other drugs die off and prevent the creation of a new generation of addicts through temperance education, the legal prohibition of alcohol and tobacco, and legal control of the non-medical use of opiates and cocaine.

On the heels of this change in public attitudes came a shift in cultural ownership of alcohol and other drug problems. As specialized addiction treatment programs closed, people with severe and prolonged alcohol and other drug problems were shuttled into the "foul wards" of urban community hospitals, the back wards of aging state insane asylums, and sentenced to rural inebriate penal colonies.

It was in this climate of disregard that those addicted to alcohol and other drugs suffered iatrogenic insults (treatment-caused injuries): mandatory sterilization, serum therapy (a procedure involving blistering the skin, withdrawing serum from the blisters and then re-injecting it as an alleged aid in withdrawal), and bromide therapy (anesthesia-aided detoxification that was lauded in spite of its high mortality rate). Over the years, alcoholics and addicts were subjected to whatever prevailing techniques dominated the field of psychiatry, from the indiscriminate application of chemical and electroconvulsive therapies, to psychosurgery, and to drug therapies that later proved to have significant potential for misuse, e.g., LSD, barbiturates, amphetamines and a wide variety of tranquilizing and anti-anxiety agents. Much of the lingering anti-medication bias in the addiction treatment field stems reflects the shadow of this history.

The few pockets of hope for the addicted during the opening decades of the twentieth century were the remaining specialty programs, a new generation of private

sanatoria and hospitals (e.g., the Charles B. Towns Hospital for the Treatment of Alcoholic and Drug Addictions in New York City that provided discrete drying out for the rich), and a clinic model of outpatient counseling. The clinic model was pioneered within the Emmanuel Church of Boston (1906) and utilized a unique program of lay therapy that brought individuals in recovery like Courtenay Baylor, Francis Chambers and Richard Peabody into the role of lay alcoholism psychotherapists. These lay therapists were the precursor to today's addiction counselor. The Emmanuel Clinic also organized its own mutual aid fellowship (the Jacoby Club) for those it treated.

When were the first recovery support groups founded in the U.S.?

Recovery mutual aid societies have a very long history in the United States. The earliest of these societies grew out of Native American religious and cultural revitalization movements. Native American recovery "circles" date from the 1730s and were particularly vibrant during the nineteenth century. Some of the most prominent leaders of these movements included Wangomend, the Delaware Prophets (Papoonan, Neolin), the Kickapoo Prophet (Kenekuk), the Shawnee Prophet (Tenskwatawa) and Handsome Lake (Ganioda'yo).

By the 1830s, Euro-American alcoholics were seeking sober refuge within local temperance societies, but it wasn't until the Washingtonian Movement of 1840 that Euro-American alcoholics banded together in large numbers for sobriety-based mutual support. The Washingtonians rapidly grew to a membership of more than 400,000 and then collapsed, with many recently sobered alcoholics moving underground via the creation of sobriety-based Fraternal Temperance Societies. John Gough and John Hawkins were among the most prominent Washingtonian speakers/organizers of this period. They spent most of their adult lives organizing local recovery support groups, providing personal consultations to alcoholics and their family members and maintaining a prolific correspondence with people seeking or in recovery. When the Fraternal Temperance Societies were torn with political conflict or lost their service ethic to the still-suffering alcoholic, they were replaced by the Ribbon Reform Clubs and other local sobriety-based fellowships such as the Drunkard's Club in New York City. There were also alcoholic mutual aid societies that sprang up within the inebriate homes, asylums and addiction cure institutes. The most prominent of the early recovery mutual aid societies are displayed in table Figure 4 (White, 2001a).

Figure 4: 18th-19th Century Recovery Mutual Aid Societies

Native American Religious/Cultural
Revitalization Movements (1730s-present)
Washingtonian Movement (1840)
Fraternal Temperance Societies (mid-1840s)
Ribbon Reform Clubs (1870s)
The Drunkard's Club (early 1870s)
Institutional Support Groups
—Ollapod Club (1864-1868)
—Godwin Association (1872)
—Keeley Leagues (1891)
Business Men's Moderation Society (1879)

The nineteenth century mutual aid societies collapsed in tandem with the inebriate homes and asylum. Only a few local recovery support fellowships (e.g., the Jacoby Club in Boston) filled the void between this collapse and the founding of Alcoholics Anonymous (A.A.) in 1935. A.A. is the standard by which all other mutual aid groups are evaluated due to its size (2.2 million members and more than 100,000 groups; 1.1 million members in the United States), its geographical dispersion (more than 175 countries) and its longevity (more than 65 years) (http://www.alcoholics-anonymous.org). The last half of the twentieth century witnessed growing varieties of A.A. experience reflected in the growth of specialty groups (e.g., women, young people, newcomers, old-timers, gay and lesbian meetings) as well as religious (the Calix Society; Jewish Alcoholics, Codependents and Significant Others—JACS) and non-religious (A.A. for Atheists and Agnostics) adjuncts to A.A. The A.A. program has been adapted for family members (Al-Anon), for persons addicted to drugs other than alcohol (Narcotics Anonymous, Cocaine Anonymous), for persons experiencing co-occurring disorders (Dual Disorders Anonymous, Dual Recovery Anonymous), and for nearly every other imaginable human problem. Also evident are a growing number of secular alternatives to A.A. (Women for Sobriety, Secular Organization for Sobriety, Rational Recovery, SMART Recovery, LifeRing Secular Recovery, and Moderation Management (White, in press) (See Figure 5).

Figure 5: 20th-21st Century Recovery Mutual Aid Societies

Jacoby Club (1909)
United Order of Ex-Boozers (1914)
Alcoholics Anonymous (1935)
—Calix Society (1949)
—JACS (1979)
Alcoholics Victorious (1948)
Narcotics Anonymous (1947/1953)
Al-Anon (1951)
Women for Sobriety (1975)
Cocaine Anonymous (1982)
Dual Disorders Anonymous-1982
Secular Organization for Sobriety (1985)
Rational Recovery (1986)
Dual Recovery Anonymous-1989
Moderation Management (1993)
SMART Recovery (1994)
LifeRing Secular Recovery (1999)

How have policies and laws toward alcohol, tobacco and other drugs evolved over the past century?

By 1850, the American temperance movement had shifted its strategy from promoting the moderate use of fermented alcohol to promoting total abstinence from all alcoholic beverages and advocating the legal prohibition of the sale of alcohol. Experiments with local and state prohibition led to a drive for national prohibition, ratification of the Eighteenth Amendment to the Constitution, and passage of the Volstead Act (the enforcement provisions of prohibition). National prohibition was inaugurated in 1919 and successfully reduced alcohol-related problems during the early twenties. Alcohol-related problems rose in the late twenties as the illicit alcohol trade increased. By the late 1920s, there was growing sentiment that the “noble experiment” of prohibition was failing. National prohibition came to an end in 1933 with the ratification of the Twenty-first Amendment to the Constitution.

The first anti-narcotics ordinance in the United States, a local ordinance passed in 1875 in San Francisco, was aimed at suppressing the Chinese opium dens. This was followed by other municipal ordinances and state laws aimed at the control of opium, morphine and cocaine. What was emerging by the end of the nineteenth century was a policy of having physicians serve as gatekeepers for the legitimate distribution of these drugs (prescription laws) and the criminalization of the non-medical sale of these substances.

The first federal law addressing psychoactive drugs other than alcohol and tobacco was the Pure Food and Drug Act of 1906. This act, which required that all medicines containing alcohol, opiates or cocaine be so labeled, had two effects. It quickly lowered rates of narcotic addiction and it banished most of the bottled addiction cure frauds. The most historically significant piece of drug legislation—the Harrison Anti-Narcotic Act—was passed by Congress in 1914. This federal act required that opiates and cocaine be sold only by a physician or a pharmacist authorized by a physician.

Between 1914-1919, a series of Supreme Court decisions interpreted the Harrison Act. In the most important of these decisions (Webb vs. the United States), the Supreme Court declared in 1919 that for a physician to maintain an addict on his or her customary dose was not in "good faith" medical practice under the Harrison Act and was an indictable offense. By one account, twenty-five thousand physicians were indicted for violation of the Harrison act between 1919 and 1935 and 2,500 went to jail.

In 1912**,** Dr. Charles Terry, director of public health in Jacksonville, Florida, opened a clinic to treat opiate addicts. This marked the beginning of clinic-directed detoxification and maintenance of narcotic addicts. Following the Webb v. United States decision, physicians in 44 communities established morphine maintenance clinics, all of which were closed by 1924 under threat of legal indictment. Many of these physicians become the harshest critics of the Harrison Act and this new era of drug repression and federal involvement in medical practice. In the same year of the Webb v. U.S. decision, the France Bill, which would have provided federal support for physician-directed, community-based treatment for addicts, came before Congress, but failed to pass. Between 1924 and 1935, treatment for narcotic addiction other than detoxification was almost non-existent.

Cannabis (marijuana) was included in the first draft of the Harrison Act, but was deleted under pressure from physicians and pharmacists on the grounds that there were many legitimate medical uses for cannabis and that its non-medical abuse was rare. An anti-marijuana campaign in the late 1920s and early 1930s led to passage of the Marihuana Tax Act of 1937 that designated cannabis a narcotic with penalties for its possession and sale similar to those for heroin.

There was also a well-organized anti-tobacco campaign of the late nineteenth and early twentieth centuries that successfully banned the sale of tobacco in many states. Following repeal of alcohol prohibition and the collapse of support for anti-tobacco

legislation in the 1930s, alcohol and tobacco became highly promoted and celebrated drugs in American society, while the non-medical use of opiates, cocaine, and cannabis will become further stigmatized and criminalized via accelerating legal penalties. The harshness of new anti-drug measures in the 1950s set the stage for the reform movements in the 1960s and 1970s.

Figure 6: Early Milestones in American Narcotic Control Policy

Year	Event	Significance
1906	Pure Food and Drug Act	Requires labeled of medicines containing opium, cocaine, cannabis and chloral
1909	Shanghai Opium Commission	First international discussion of drug control
1909	The Smoking Opium Exclusion Act	Prohibits importation of opium for smoking
1912	The Hague Opium Convention	Commits U.S. to pass drug control legislation
1914	Harrison Anti-Narcotic Act	Establishes physicians as gatekeepers of access to opiates and cocaine
1919	Webb v. United States Supreme Court decision	Threatens legal punishment for physicians medically maintaining addicts on opiates
1922	Narcotics Import and Export Act	Prohibits importation of processed morphine and cocaine into the U.S.
1924	Heroin Act	Prohibits importation of opium for use in manufacture of heroin
1937	Marihuana Tax Act	Prohibits sale and possession of cannabis
1942	Opium Poppy Control Act	Prohibits growth/harvesting of opium poppies without license
1951	Boggs amendment to the Harrison Act	Implemented mandatory minimums in sentencing of drug offenders

1956	Narcotic Control Act	Increases penalties and introduces first death penalty provision within drug control legislation

In 1966, Congress passed the Narcotic Addicts Rehabilitation Act (NARA), which provided treatment as an alternative to incarceration for narcotic addicts. This was followed by a further liberalization of drug laws in the 1970s, sparked primarily by concern with youthful drug experimentation and reports of heroin addiction among American soldiers in Vietnam. It was during the administration of President Richard Nixon that national drug policy shifted from an emphasis on law enforcement to one that placed a greater emphasis on prevention and treatment. This was followed in the 1980s by a backlash against what were perceived as "soft" approaches to the drug problem. This backlash was fueled by growing alarm about new patterns of cocaine addiction and drug-related violence. President Reagan re-allocated the national drug control budget, shifting two-thirds of the total budget into law enforcement with the remaining dollars devoted to prevention and treatment—exactly opposite the ratio established during the Nixon years.

Where earlier policy had focused resources on those drugs with greatest risks and social costs, e.g. heroin, Reagan's position of "zero tolerance" shifted the focus from treating addiction to discouraging casual drug use, particularly marijuana use. The representation of drug offenders among the state prison population jumped during the Reagan era from one in fifteen inmates to one in three inmates, with 85 percent of these offenders incarcerated on possession charges (Baum, 1996).

The explosive growth of prisons in the closing decades of the twentieth century was a product of increased incarceration of drug offenders. There are now more than 1.5 million drug-related arrests per year in the U.S. (up more than 1 million since 1980), and drug-offenders now make up more than 60% of the federal prison population (Office of Applied Statistics, SAMHSA, 2000). The racial disparities reflected within these trends are glaring. While African Americans represent only 15% of illicit drug consumers, they constitute 60% of those incarcerated in state prisons on felony drug convictions (USDJ, 2000). While the rate of pre-natal exposure of infants to drugs is the same for Caucasian and African American women, the latter are ten times more likely to be reported to child welfare authorities for pre-natal drug exposure (Neuspeil, 1996).

Figure 7: Drug Control Policy/Legislative Milestones: 1960-Present

Year	Event	Significance
1963	President's Advisory Commission on Narcotics and Drug Abuse	Recommends exploring option of treatment for drug offenders as an alternative to incarceration
1965	Drug Abuse Control Amendments	Provides strict controls on amphetamines, barbiturates and LSD
1972	President's Commission on Marijuana and Drug Abuse	Recommends relaxation of marijuana laws; 12 states follow with decriminalization laws.
1970	Controlled Substances Act	Replaced all previous drug legislation; introduces drug scheduling
1984	Crime Control Act	Increased mandatory minimum penalties for drug possession/sale; property forfeiture provisions
1977	President Carter advocates federal decriminalization of marijuana	Drug-related controversies among White House staff led to abandonment of this initiative
1980	President Reagan introduces "zero tolerance" for drug use	Restigmatization, Demedicalization, & Recriminalization of alcohol & other drug problems
1986 1988	Anti-Drug Abuse Act	Acts focuses on discouraging causal drug use; 2/3rds of funds go for law enforcement; 1/3 for prevention and treatment

There were many influences that shaped the anti-drug campaigns detailed above, but one glaring theme is the association of particular drugs with specific minority groups. The West Coast anti-opium campaign of the 1870s linked opium to the Chinese during a period of intense racial and class conflict. The first anti-cocaine laws in the South linked cocaine with violence by blacks at a time there is little evidence of widespread cocaine use among African Americans. This history continued: the drive toward alcohol prohibition tapped anti-Catholic and anti-German sentiment, the anti-heroin campaign tapped

growing fears about crime and violence by immigrant youth, the anti-cannabis campaign heavily targeted Mexican immigrants, and the anti-cocaine laws of the 1980s were targeted primarily against poor communities of color.

What led to the rebirth of treatment between 1940-1970?

Two advancements were required to lay the foundation for the rise of a national network of community-based addiction treatment programs in the 1970s and 1980s: 1) a fundamental change in public attitudes and policies, and 2) the development of credible and replicable treatment models.

A number of institutions pioneered new approaches to alcohol-related problems in the 1940s and 1950s. Their collective efforts have been christened the Modern Alcoholism Movement.

- Alcoholics Anonymous and its professional friends re-instilled optimism about the prospects of long-term recovery.
- The Research Council on Problems of Alcohol promised a new scientific approach to the prevention and management of alcohol problems.
- The Yale Center of Studies on Alcohol conducted alcoholism-related research, educated professionals, established a clinic model of outpatient treatment, and promoted occupational alcoholism programs.
- The National Committee for Education on Alcoholism, founded by Mrs. Marty Mann in 1944, waged an unrelenting public education campaign about alcoholism and encouraged local communities to establish detoxification and treatment facilities.

There were five “kinetic” ideas (developed by Dwight Anderson and Marty Mann) that were at the center of this Modern Alcoholism Movement’s re-engineering of public opinion and legislative policy.

Figure 8: Anderson and Mann’s Five “Kinetic” Ideas
1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility. (Mann, 1944)

The modern alcoholism movement was actually many movements—each aimed at changing how particular institutions viewed alcoholism and the alcoholic. The targeted institutions were those of religion, law, business, medicine and the media. The success of the movement was indicated by the increased percentage of American citizens who viewed alcoholism as a sickness from 6% in 1947 to 66% in 1967, and the number of professional organizations making public pronouncements about alcoholism in the 1950s and 1960s (See Figure 9).

Figure 9: Key Policy Statements on Alcoholism (1950-1970)

Year	Organization	Position
1951	American Hospital Association (AHA)	Resolution on "Admission of Alcoholic Patients to the General Hospital" declares alcoholism a "serious health problem"
1952	American Medical Association (AMA)	Defines alcoholism
1956	AMA	Resolution calling on general hospital to admit the alcoholic as a "sick individual"
1957	AHA	Resolution urging local hospitals to develop programs for the treatment of alcoholism
1963	American Public Health Association	Resolution declaring alcoholism a treatable illness
1965	American Psychiatric Association	Publishes a statement recognizing alcoholism as a disease
1967	AMA	Resolution that alcoholism is a "complex disease that merits the serious concern of all members of the health professions"

The shift in public attitude and professional policy were crystallized in the work of the Cooperative Commission on the Study of Alcoholism whose 1967 report called for a comprehensive, national approach to the prevention and treatment of alcohol problems as well as investments in alcoholism-related professional training and research. The Commission report provided a blueprint for the modern system of alcoholism treatment.

The first state first state alcoholism commissions were organized in the 1940s, and several alcoholism treatment modalities emerged between 1940 and 1965, including:

- hospital-based detoxification and brief (5 day) treatment models via A.A. collaboration with hospitals in Akron, New York City, Cleveland, Philadelphia, Chicago,
- an outpatient clinic model pioneered in Connecticut and Georgia,
- a residential model (the "Minnesota Model of Chemical Dependency Treatment") developed at Pioneer House, Hazelden and Willmar State Hospital, and

- a halfway house movement of the 1950s that championed the need for post-treatment recovery support services.

Federal support for alcoholism services grew in the 1960s through funding from the National Institute of Mental Health and the Office of Economic Opportunity. The decades-long campaign of the Modern Alcoholism Movement reached fruition with the passage of the Comprehensive Alcoholism Prevention and Treatment Act of 1970. This legislative milestone (often referred to as the "Hughes Act" for its champion, Senator Harold Hughes of Iowa), created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to lead a federal, state and local partnership to build, staff, operate and evaluate community-based alcoholism treatment programs across the United States. The number of alcoholism programs in the U.S. jumped from a few hundred in 1970 to more than 4,200 programs by 1980.

The growth of treatment programs for addiction to drugs other than alcohol went through a similar process. First, there were reform campaigns that called for the movement of addicts from systems of control and punishment to systems of medical and psychological care. The earliest of these efforts resulted in the creation of two federal "narcotics farms" designed to rehabilitate narcotic addicts entering the federal prison system. These were opened in Lexington, Kentucky in 1935 and Fort Worth, Texas in 1938. Evaluations of these programs showing exceptionally high relapse rates for addicts returning to their communities created pressure to create local, community-based treatment alternatives. The work of the American Medical Association and the American Bar Association in the 1950s and 1960s played an important role in calling for the shift from a criminal justice to a public health approach to the problem of addiction. Growing drug use by white youth in the 1960s tipped the scales toward a major investment in addiction treatment.

To build a treatment system required replicable models of intervention and post-treatment recovery support. These came in four stages: the founding of Narcotics Anonymous in 1953, the birth of the therapeutic community via the founding of Synanon in 1958, the development of methadone maintenance by Drs. Dole, Nyswander and Kreek in the mid-1960s; and the emergence of a variety of drug-free outpatient therapies for youthful polydrug abuse during the late 1960s. These efforts came together in a 1971 in an executive order by President Richard Nixon that created the Special Action Office for Drug Abuse Prevention and the passage of the Drug Abuse Treatment Act of 1972. This law created a counterpart to NIAAA—the National Institute on Drug Abuse (NIDA)—to support the development of a national network of addiction treatment programs. The number of such programs in the U.S. increased from less than 100 in 1970 to more than 1800 in 1975. The era of modern treatment had begun, with about two thirds of the national drug control budget focused on demand reduction (prevention and treatment) through the Nixon, Ford and Carter administrations (Baum, 1996; Massing, 1999).

What were some of the most significant milestones in the modern history of addiction treatment?

The modern field of addiction treatment has experienced three phases in its development. The focus of the first stage (1970-1980) was on the development of federal, state and local organizational infrastructures through which treatment services could be planned, delivered and evaluated. This required:

- codification of treatment processes, e.g., the National Council on Alcoholism's

development of diagnostic criteria for alcoholism (1972),

- the development of national (NIAAA and NIDA) and state training systems to educate and professionalize addiction treatment personnel,
- the infusion of resources into research on addiction and treatment effectiveness,
- the emergence of addiction counseling as a "new profession" via the founding of the National Association of Alcoholism Counselors and Trainers (the precursor to NAADAC: The Association of Addiction Professionals) (1972) and state counselor associations,
- studies on core competencies of addiction counseling (the Littlejohn and Birch and Davis Reports of the mid-1970s) that formed the foundation of state counselor certification systems,
- the development of national accreditation and state licensure standards for treatment programs (early 1970s), and
- the highly controversial organizational integration of alcoholism and drug abuse treatment programs (1975-1985).

This first phase was resulted from hard-fought changes in public perception of alcoholism and the alcoholic created to a great extent by declarations of recovery from alcoholism by many prominent Americans, including First Lady Betty Ford. The National Council on Alcoholism played a significant role in this achievement via its Operation Understanding campaigns—press conferences held in 1976 and 1978 at which prominent people from diverse professions publicly announced their successful recovery from alcoholism.

The second phase in the development of modern treatment was characterized by an explosive growth of addiction treatment driven by the increase in inpatient hospital and for-profit residential treatment programs (and franchises). This initial trend was spurred by the decision of many insurance companies to begin offering alcoholism treatment benefits within their health policies. Rapidly rising costs of addiction treatment and exposure of ethical abuses related to aggressive marketing, inappropriate admissions and lengths of stay led to a rapid curtailment of these benefits and the emergence of an aggressive program of managed behavioral health care during the late 1980s. Between 1988 and 1993, a large number of these programs were closed, and others shifted their emphasis from inpatient to outpatient services. This period of explosive growth and backlash lasted roughly from 1981 to 1993. There was also an ideological backlash during this period that challenged many of the foundational concepts of addiction treatment, e.g., the disease concept of alcoholism.

The modern field of addiction treatment moved into a stage of maturity as it entered the twenty-first century. This maturation is evident in the aging and beginning exit of its first and second generation leaders, the expansion of programs for special populations, near universal interest in bridging the gap between research and front-line clinical practices, and the movement of treatment services into other social systems, e.g., the child welfare system, the criminal justice system, and public health agencies (particularly those involved in HIV/AIDS-related services). There is also evidence of the field's philosophical maturation via the shift from ideological intolerance (single-modality programs believing their approach was the only way to treat all addiction) to a growing recognition that substance use disorders spring from multiple etiological pathways, unfold in diverse patterns and needs, respond to a variety of treatments, and resolve themselves through multiple pathways and styles of long-term recovery.

Some of the most important technical achievements during this evolution of modern treatment include research-validated screening/assessment instruments and diagnostic and placement criteria; early intervention programs (EAP, SAP, Family Intervention); replicable treatment models that span multiple and linked levels of care; effective outreach and engagement techniques (e.g., motivational interviewing); an expanded menu of psychopharmacological adjuncts; evidence-based, manualized therapies; age-, gender- and culturally-informed treatment; relapse prevention tools; and an expansion of post-treatment recovery support services (see Chapter 19 for a discussion of recovery tools). The most significant systems achievement during the modern era has been the resilience of the federal, state and local partnership that has shared responsibility for building, staffing, operating, monitoring and evaluating community-based addiction treatment programs.

As this book goes to press, there are two movements that promise, by their success or failure, to reshape the future of addiction treatment. The first is a treatment renewal movement that seeks to get the field of addiction treatment ethically re-centered, move addiction treatment providers back into deep relationships with the communities out of which they were born, and to re-link treatment to the larger and more enduring process of addiction recovery (White, 2002a). The second is a new recovery advocacy movement led by recovering people and their families that is trying to counter the restigmatization, demedicalization and recriminalization of alcohol and other drug problems. These grassroots organizations are putting a face and a voice on recovery, pushing pro-recovery policies, and working to expand treatment and recovery support services within local communities (White, 2001b). The energy generated by these two movements makes it an exciting time to enter the world of addiction treatment.

So what does this history tell us about how to conduct one's life in this most unusual of professions?

The lessons from those who have gone before you are very simple ones. Respect the struggles of those who have delivered the field into your hands. Respect yourself and your limits. Respect the individuals and family members who seek your help. Respect (with a hopeful but healthy skepticism) the evolving addiction science. And respect the power of forces you cannot fully understand to be present in the counseling process. Above all, recognize that what addiction professionals have done for more than a century and a half is to create a setting and an opening in which the addicted can transform their identity and redefine every relationship in their lives, including their relationship with alcohol and other drugs. What we are professionally responsible for is creating a milieu of opportunity, choice and hope. What happens with that opportunity is up to the addict and his or her god. We can own neither the addiction nor the recovery, only the clarity of the presented choice, the best clinical technology we can muster, and our faith in the potential for human rebirth. The individuals, families and communities impacted by alcohol and other drugs need and deserve a new generation of addiction counselors who are willing to dedicate their lives to carrying forth the movements chronicled in this chapter. For those willing to follow that calling, I bequeath you a field whose rewards are matched only by its challenges (Adapted from White, 1998).

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Glossary

American Temperance Movement: A social movement arising in the early nineteenth century that, following a brief call for moderation of alcohol consumption, generated mandatory temperance education, drinking age laws and eventually the drive to legally prohibit the sale of alcohol.

Inebriety/Inebriate: Inebriety was the term for what today would be called addiction; the person suffering from addiction was known as an inebriate.

Inebriate Asylums: Medically-directed institutions for the long-term care of the inebriate.

Inebriate Homes: Residential homes for the care of inebriates that portrayed recovery as a sobriety decision (pledge signing), a process of moral reformation, and a process of mutual surveillance and support.

Habitues: A nineteenth century term used most frequently to depict those who had become dependent upon opium or morphine, later expanded to encompass those addicted to any drug.

Harrison Act: The 1914 act that set the stage for the criminalization of the status of narcotic addiction in the United States.

Keeley Institutes: The largest chain of for-profit addiction cure institutes that flourished in the late nineteenth century.

Kinetic Ideas: Ideas and phrases thought to have power in galvanizing public opinion, e.g., “alcoholism is a disease.”

Lay Therapists: Recovered alcoholics trained to serve as lay psychotherapists within the Emmanuel Clinic in Boston and later used to depict recovered counselors who lacked formal training in medicine, psychology or social work.

Modern Alcoholism Movement: Term applied to the post-Repeal efforts of multiple organizations to change American perceptions of alcoholism and the alcoholic.

NARA: Narcotic Addict Rehabilitation Act that expanded access to treatment for narcotic addiction in the 1960s.

Narcotics Farms: Term applied to the federal prisons in Lexington, Ky and Forth Worth, TX that were designated for the treatment/containment of narcotic addicts within the federal prison system.

Volstead Act: The 1919 enforcement arm of federal prohibition of the sale of alcohol.

Webb v. United States: The 1919 Supreme Court decision that prohibited physicians from maintaining addicts on their "usual and customary dose"—the practical implication was the transfer of narcotic addicts from the medical community to the criminal justice community.



Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2004). Transformational change: A historical review. IN SESSION: Journal of Clinical Psychology, 60(5), 461-470. Posted at **www.williamwhitepapers.com**

Transformational Change: A Historical Review

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Abstract

Recovery from alcoholism can occur through a process of psychological death and rebirth. Generating a new person within a body once occupied by another, transformational change (TC) stands as a life-defining experience demarcating before (old self) and after (new self). The TC experiences of 7 individuals (Handsome Lake, John Gough, Francis Murphy, Jerry McAuley, Bill Wilson, Marty Mann, Malcolm X) are presented whose recoveries from addiction catalyzed larger abstinence-based mutual aid, advocacy, or religious/cultural revitalization movements. Psychotherapists are encouraged to respect the healing power of the TC experience, avoid aborting the TC experience via superficial amelioration of its more disquieting manifestations, interpret the TC experience in ways that solidify and sustain the change process, and help bridge the TC experience and the construction of a new identity and lifestyle.

Key words: transformational change, alcoholism recovery, mutual aid movements

Introduction

Some experiences measured in moments can forever rend a life into the temporal categories of before and after, and leave in their psychological wake an essentially new person. The evidence of such transformation exists in radical and sustained alterations of character, identity, and interpersonal relationships. Transformational change (TC) experiences constitute the most dramatic but least understood mechanism of human change, making it difficult for psychotherapists to recognize, understand, and respond to such experiences. TC experiences have added historical import due to their propensity to catalyze larger religious, social, and therapeutic movements.

The link between transformational change of the individual and the rise of larger social movements has a long history, particularly within the religious arena. The lives of Isaiah, Jeremiah, Ezekiel, St. Augustine, Mohammed, Buddha, Luther, and Wesley illustrate how agonizing

personal conflict can be resolved through sudden, life-transforming, and history-shaping experiences. Of all such historical accounts, it is on the road from Jerusalem to Damascus where Saul of Tarsus, the orthodox Jew and Christian persecutor, is transformed into St. Paul, the Christian missionary, that one finds the core elements of the TC experience: a germinating personal crisis; a breakdown and breakthrough experience; and a radically and positively altered identity and life course.

Seven TC Examples

Clinical interest in transformational change stems from its potential healing effects. The therapeutic power of the TC experience and the ability of such experiences to spawn therapeutic movements are vividly illustrated in the history of addiction recovery. In this article, I will analyze the TC experiences of seven individuals whose recoveries from addiction spawned larger mutual aid, advocacy or cultural revitalization movements. Individuals chosen met three criteria: 1) they suffered from severe and persistent alcohol or other drug-related problems; 2) they resolved these problems through a brief experience that was unplanned, and intense and whose effects were positive and enduring; and 3) they went on to lead an abstinence-based mutual aid, advocacy or religious/cultural revitalization movement. Our seven subjects are as follows.

Handsome Lake (Ganioda'yo) (1735-1815) was a Seneca Indian who suffered from years of drunkenness. He was thought to have died in 1799, but awoke during preparation for his burial announcing that the Great Spirit had visited him in his death and sent him back to life with a message for Indian people. For the next 16 years, he remained sober and promulgated what came to be known as the Code of Handsome Lake (Longhouse Religion). This religious and cultural revitalization movement, through its moral code and regular meetings ("circles"), created an effective cultural framework for alcoholism recovery that continues to be practiced among some Native tribes today (Parker, 1913).

John Gough (1817-1886) lived a debauched life until a stranger, seeing Gough's drunken and forlorn state, stopped and befriended him on the street. The stranger's expressions of kindness and hope marked an emotional turning point in Gough's life. He signed the pledge and went on to become a leader of the Washingtonian movement of the early 1840s, bringing thousands into recovery through his charismatic speeches (more than 8,000 in America and Europe), personal consultations, and prolific correspondence (Gough, 1870).

Francis Murphy (1836-1907) was in jail for drunkenness in 1871 when a missionary's words touched his heart and led to his conversion and recovery. Murphy founded the Blue Ribbon Reform Club Movement that brought thousands of alcoholics into recovery throughout New England and the Midwest (Daniels, 1877).

Jerry McAuley (1839-1884), a notorious alcoholic within the criminal underworld of New York City, underwent a series of powerful conversion experiences during and following his incarceration in Sing Sing Prison. McAuley achieved sobriety, and in 1872 founded an institution (the Water Street Mission) that pioneered evangelical outreach to the drunkard and inspired the growth of urban rescue missions and rural inebriate colonies throughout the United States (Offord, 1885).

Bill Wilson (1895-1971) reached a point of desperation in 1934 while hospitalized for fourth time for alcohol detoxification. After he cried, "If there is a God, let Him show Himself!" the room became ablaze with light and Wilson was overwhelmed by a Presence and a vision of being at the summit of a mountain where a spirit wind blew through him, leaving the thought, "You are a free man." Wilson never took another drink and went on to co-found Alcoholics Anonymous, a mutual aid society whose worldwide membership now exceeds two million. (Alcoholics Anonymous, 1984).

Marty Mann (1904-1980) was undergoing treatment for alcoholism when

an incident occurred that enraged her. While in this state, her eyes fell upon an opened pre-publication copy of the book, Alcoholics Anonymous, where she saw the words “We cannot live with anger.” The next thing Mann recalls is being on her knees crying and praying. She arose knowing she was a different person, that she was “totally and completely free.” She became the first women to successfully recover within Alcoholics Anonymous, and, in 1944, founded the National Committee for Education on Alcoholism. Mann became a central figure in the modern alcoholism movement and one of America’s most successful public health reformers (Brown & Brown, 2001).

Malcolm X (1925-1965) was an addicted street hustler who, following his religious conversion, became the driving force behind the dramatic growth of the Nation of Islam during the 1950s and early 1960s. His transforming moment occurred in a prison cell via a vision of W. D. Fard, the deceased messiah of the Nation of Islam. Through the example and influence of Malcolm X, the Nation of Islam became a cultural pathway of addiction recovery for many African-American men (Malcolm X & Haley, 1964; Myers, 1993).

A considerable body of literature helps analyze the experiences of these seven individuals and explore their clinical significance. This literature includes published accounts of their lives as well as the early psychological studies of religious conversion by Edwin Starbuck and William James; the studies by Harold Begbie and Harriet Monroe of “twice-born men” (the conversion of alcoholics in rescue missions); Harry Tiebout’s psychiatric studies on the role of surrender in recovery from alcoholism, and the more contemporary studies of James Loder and William Miller and Janet C’de Baca.

Characteristics of TC Individuals

Do those who recover from addiction through a TC experience differ from those whose recoveries are marked by more typical, incremental processes of change? Might the TC experience simply be a leap into health by individuals with low problem severity, high recovery resources, and a pre-existing affinity for spiritual or religious experience? This latter question has not been definitively answered within the research on transformational change, but no such pattern exists in our sample. Prior to their TC experience, accounts of these seven lives are filled with reports of acute withdrawal, delirium tremens, fear of insanity, occupational instability, institutionalization, family alienation, and social ostracism. Pledges of abstinence by our subjects were repeatedly broken, and all prior professional interventions had failed. Wilson and Mann had more than 10 alcohol-related treatments between them. Three of the seven cases had criminal histories ranging from murder (Murphy) and highway robbery (McAuley) to drug dealing, pandering, and burglary (Malcolm X). As a group, they were mostly self-proclaimed atheists, with one (Malcolm X) so hostile towards religion that he was referred to as “Satan” by his fellow prison inmates. None of the seven individuals profiled would have been judged a likely candidate to achieve prolonged sobriety or to become the leader of a history-shaping social movement.

The Context of Transformational Change

The TC experience is so intensely personal that the larger contexts in which these experiences unfold can be easily overlooked. The personal unrest of our subjects was mirrored by great social unrest within their cultural environments. Handsome Lake experienced his crisis of change at a time when Native tribes were under physical and cultural assault. The collapse of the stock market and the Great Depression sorely tested the “I am the master of my fate” mantra of Bill Wilson’s generation. Malcolm X’s transformation unfolded during the rise of black consciousness and the birth of the civil rights movement. TC experiences often occur within a larger context of political, economic, or social unrest when traditional ideas and sources of support are collapsing.

The developmental timing of the recovery-inducing TC experience varies widely, but seems to differ from that of most religious conversions. Starbuck (1901), in his classic study of religious conversion, noted that such experiences most often occur between early and mid-adolescence and only rarely occur after age 20. In contrast, the seven TC experiences noted here occurred much later in life, ranging from age 25 (Gough) to 64 (Handsome Lake). There is a potentially significant confluence of location: isolation-induced introspection seems a common pre-condition for the TC experience. Five of our seven cases underwent their breakthrough experience while institutionalized—three in a jail cell (Murphy, McAuley, and Malcolm X), and two while alone in a hospital or sanatoria (Wilson and Mann).

Types and Characteristics of Transformational Change

There have been many efforts to catalogue religious and secular varieties of TC experiences. Starbuck and James noted two types: a volitional type in which the change is gradual and consciously directed, and a self-surrender type which is rapidly climactic and whose direction seems to come from outside the self. Miller and C'de Baca (2001) also found two types: an insightful type (breakthrough of internal awareness) and a mystical type (sense of being acting upon by an outside force). Of the seven individuals profiled, Gough's TC experience is the most distinctly secular and closest to the insightful form of TC experience.

It has yet to be determined whether the TC experience is a "rapidization of change" (Oates, 1978) or is a qualitatively different process. Bill Wilson (1988) argued that his experience was just the extreme condensation of the endless small steps more typically taken by AA members who successfully recovery from alcoholism. Others, such as Malcolm X, rarely spoke of their TC experience, perhaps in an effort to minimize the differences between themselves and their followers.

TC experiences suggest five distinct characteristics. First, the TC experience is sudden, unplanned, and unanticipated. The subject is more a recipient of the experience than an initiator or director of it. This does not mean that the subject is a complete bystander of the TC experience. Pasquier (1978) described a point in the TC experience in which the subject is free to retreat from the experience or move forward through the experience. This movement through resistance into a letting go and embrace of the TC experience has been characterized as a "passage" or "surrender."

Second, TC experiences are extremely vivid, allowing TC individuals to recount their experiences in extreme detail. Some of the more vivid dimensions include:

- desperate entreaties for help (Wilson's plea, "If there be a God, let him show Himself!") (AA, 1984, p. 121)
- death-like trances and rebirths (Handsome Lake's death and awakening),
- rooms lighting up (Murphy, McAuley and Wilson)
- vivid smells (McAuley's report of the fragrance of sweet flowers)
- felt presence of spiritual beings (Wilson's awed proclamation, "This must be the great reality. The God of the preachers.") (AA, 1984, p. 121)
- visions and spiritual encounters (Handsome Lake, Malcolm X)
- voices (McAuley hearing, "My son, thy sins, which are many, are forgiven."(Offord, 1885, p. 19)
- rapid heartbeat, profuse sweating, weeping (McAuley, Mann)
- profound breakthroughs of awareness and understanding
- a flooding sense of love, hope and well-being (Gough and Wilson)
- a sense of newness, joy, ecstasy and release (Wilson's experience of the words, "You are a free man"; Mann's recognition that she was "totally and completely free!")
- physical touch (McAuley's report: "…in the very height of my distress, it seemed

as if a hand was laid upon my head...") (Offord, 1885, p. 19)
- physical prostration (near-universal reports of being literally brought to one's knees)
- extreme disorientation (McAuley: "I did not know if I was living or not...") (Offord, 1885, p. 19).

Third, the effects of TC are comprehensive. In his 1909 study of conversion-induced recovery from alcoholism, Begbie (1909) emphasized that these conversions represented not a change in behavior (the absence of drinking) but a revolution in character. The change experiences noted in our case studies reflect more than changes of appearance or habits of living; they involve profound change in the very architecture of personal identity. The obliteration of longstanding and excessive appetites for intoxicants is a side effect rather than the essence of the TC experience. This change is so total that the TC experience across time and cultural traditions has been marked by a three-part personal narrative: who I was, what happened, and who I am today.

Studies of TC experiences do note the potential for partial or incomplete transformations. Tiebout (1953) observed that some alcoholics experience only a transient or intellectual experience of surrender that removes (sometimes forever) the consumption of alcohol, but leaves in its wake a distinctly immature person whose personality defects continue unchecked. Tiebout distinguished this skin-deep compliance from the deeply internal experience of surrender. In Tiebout's view, the former produces a "selective surrender" to alcohol but not a broader surrender to life.

Fourth, the changes elicited by the TC experience are positive. This is such a prominent feature of the TC experience that some investigators (Miller and C'de Baca, 2001) have incorporated this dimension of positiveness into the very definition of TC. While the positive fruits of TC are clear in our seven cases, other investigators have cautioned that this is not always the case. Salzman (1954), for example, notes that the TC experience may be either progressive (maturational) or regressive (psychopathological). The former is characterized by honesty, humility, tolerance, generosity; the latter by rigidity of belief, zealous proselytizing, intolerance or hatred of infidels, and propensity for aggression and martyrdom.

Fifth, the TC experience, while brief, is enduring in its effects. Most of the cases had a single TC experience that lasted from a few minutes to several hours. Others had a series of TC experiences, each more intense than the one that preceded it. Handsome Lake, Wilson and Mann typify the single, unforgettable TC experience, while Gough and McAuley typify those who report multiple conversions and re-commitments. In terms of the ability of the TC experience to suppress drinking, five of the eight of the individuals profiled never drank again after their TC experience. Gough and McAuley experienced several early relapses before achieving permanent sobriety, and Mann experienced three brief relapses in 1939-1940 and one brief relapse two decades later. Where relapse did occur, it was more a brief fluctuation of commitment rather than a permanent abandonment of faith or a reversal of the changes of character that were the product of the TC experience.

Stages of Transformational Change

In spite of their unintentionality and suddenness, TC experiences are built upon a personal history and often constitute a critical detonation point of past experience (Loder, 1989). The process of moving toward this detonation point has been characterized by James (1902/1985) as one of "organic ripening." Clark (1958) described three stages of the entire process: unrest and conflict (feelings of unworthiness, shame and incompleteness); the "conversion crisis" (sudden breakthrough of illumination); and a sense of "peace, release and inner harmony." Loder (1989) noted five similar stages in what he called the "logic of transformation": conflict (a dissonance in the soul); interlude for scanning (search for a

resolution); intuitive insight (breakthrough experience of truth); release and openness for new patterns of thinking and being; and interpretation and verification (experience is filtered through significant others for validation). Both models closely reflect the TC experiences under investigation.

The seven cases detailed here share five elements: 1) a period of isolation and traumatic discontent, 2) exposure to a message/messenger of hope, 3) a breakthrough experience, 4) validation of the experience, and 5) entrance into a community of shared experience.

Isolation and Traumatic Discontent. The problems of our subjects worsened prior to their TC experiences, and their psychological defenses became exaggerated, perhaps in an effort to sustain their historical identity and head off the coming crisis. Estranged from family and friends, they found themselves without an avenue of escape. Murphy's oldest friend not only failed to bail him out of jail, but also recommended that he be locked up. Wilson overheard his wife and doctor discussing the potential need for his legal commitment. In this period of heightened introspection, our subjects found themselves experiencing the germinating emotions of the TC experience: imperfection, sinfulness, wretchedness, incompleteness, restlessness, fear, estrangement, depression, and desperation (Starbuck, 1901).

In the absence of defensive filters and distortions, the idealized self was shattered and the degradation of the real self was revealed in its loathsome details. Wilson described his deep depression at this moment as a "terrifying darkness" and an "agony of the spirit" (AA, 1984, p. 120). Such acute emotional pain typified Begbie's (1909, p. 54) descriptions of the conversion crisis of the alcoholic: "A wave of shame swept over him; he came out of his vision with this sense of horror and shame drenching his thought. For the first time in all his life he was stunned be realization of his degradation and infamy. He knew himself." This initial stage of the TC experience has a destructive dimension involving the collapse of the former self and its defensive armor.

Exposure to a Message/Messenger of Hope. During these darkest hours, our subjects were provided through word or relationship a hope that their stained identities could be cleansed. This hope came from varied sources: the words of the Great Spirit to Handsome Lake, the kindness of a befriending stranger to Gough, the encouragement of a converted prize fighter to McAuley, the visit of Captain Cyrus Sturdevant to Murphy's jail cell, Ebby T.'s visit to Bill W., Dr. Tiebout's gift of a copy of Alcoholics Anonymous to Marty Mann, and letters from his brother Reginald to Malcolm X. Each of our subjects encountered a messenger and a message of hope.

A Breakthrough Experience. The core elements of the experience of transformational change seem remarkably consistent across time and culture. These elements include the experiences of surrender, confession, forgiveness, awe, connectedness, ecstasy, release, newness, and tranquility. There is a perception of truth, a reconciliation of conflicting ideas and emotions, and a new sense of order and beauty so complete as to form a passage from one identity to another.

Validation of the Experience. To state that the TC experience is vivid and permanent does not mean that the experience is accepted without question. Most such experiences require interpretation and validation. Two incidents vividly portray the importance of such validation. Bill Wilson and Marty Mann questioned the genuineness of their TC experiences. Both shared the details of their TC experience with their physicians—William Silkworth and Harry Tiebout, respectively—and pointedly asked if they were losing their minds. Silkworth and Tiebout labeled the experiences in spiritual rather than medical terms and encouraged their patients to "hang on" to this experience. Wilson received further validation when he found his experience described in William James' Varieties of Religious Experience and by the expressed confidence of his wife ("From that moment on, I shared his confidence in the future.") (AA, 1984, p. 125).

Entrance into a Community of Shared Experience. Loder (1989) observed that the "convictional experience" is incomplete until there is a social context within which it can be validated and sustained among those who have shared the experience. Efforts to create or to enter into a community of shared experience were clearly evident in our case studies. This need to share "experience, strength and hope" constitutes the bridge through which the highly personal TC experience shifts to the communal and the historical, moving across generational, geographical, religious and cultural boundaries.

TC and Therapeutic Social Movements

There is often within the TC experience an intense need to "testify" and offer "witness" about one's experience and new understandings. This serves multiple needs: it provides a way to relive, sustain and celebrate the experience; it reaffirms the behavioral commitments that came out of the experience; and it provides a vehicle to reach out to others. The zeal with which our protagonists promoted their new beliefs was intense and sustained. All seven of the individuals spent the remainder of their lives promoting the new values that grew out of their TC experiences. Of the seven people we profiled, two (Gough and Murphy) left an extensive body of reflections but no codified map for change, two left oral teachings that were later codified by their followers (Handsome Lake, McAuley), and three detailed the active ingredients of their therapeutic/activist programs. The latter include Wilson's Twelve Steps of Alcoholics Anonymous, Mann's five kinetic ideas of the National Committee for Education on Alcoholism, and the Nation of Islam's six-point process for addiction recovery.

What these codified experiences shared in common was a rationale for abstinence from alcohol and other drugs, a framework of sustained mutual support, a moral code of living that defined sobriety as more than the absence of drinking, and a call to reach out to other lost souls. The service ethic is present throughout, from the Washingtonian mantra, "You've been saved, now save another" to what Malcolm X referred to as "fishing for the dead" (Myers, 1993, p. 82).

There are distinct differences in the teachings of Handsome Lake and Malcom X when compared to the teachings of other TC individuals, with the former more focused on communal than individual experience. All were preoccupied with power and control but found different answers to how these issues related to sobriety. Gough, Murphy, McAuley, Wilson and Mann saw their salvation rooted in the abdication of power–in the act of surrender. In contrast, Handsome Lake and Malcolm X portrayed alcohol and other drugs as poisons that robbed their communities of life and vitality. They called for the assertion of power to expel these poisons and to tap cultural roots to purge the shame and self-hatred that rendered such poisons a welcomed balm.

Clinical Implications

With full awareness that TC experiences that trigger larger social movements may not be representative of the broader pool of such experiences, I would offer five concluding recommendations for the clinical practitioner.

1. Sacred and secular varieties of transformational change represent legitimate ways in which individuals can profoundly, positively, and permanently redefine their personal identities and interpersonal relationships. These experiences offer evidence that the trajectory of the most incorrigible lives can be fundamentally altered.

2. The therapist can set the stage for TC by creating a psychological sanctuary conducive to self-evaluation, encouraging periods of isolation, and heightening dissonance between the idealized and real self.

3. When intervening with an individual who may be in the midst of a TC experience, great care should be taken in prematurely aborting this experience via interventions aimed at alleviating its discomforting aspects. As William James (1902/1985, p.

187) noted, “When the new centre of personal energy has been subconsciously incubated so long as to be just ready to open into flower, ‘hands off’ is the only word for us, it must burst forth unaided!” The TC experience has its own momentum and direction that should not be altered.

4. Psychotherapists can validate and interpret TC experiences in ways that solidify and sustain the change process. It is best to avoid framing visions and messianic callings in terms of psychopathology (e.g., hallucinations, delusions) until the sources and fruits of such experiences are clear. As these case studies indicate, symptoms of acute psychopathology can also signal a process of positive self-transformation and the beginnings of a movement that could touch hundreds of thousands of lives. It gives one pause to think that if William Silkworth had interpreted Bill Wilson’s breakthrough experience in medical rather than spiritual terms, A.A. might never have been born. Therapists can help clients gain passage through the TC experience by acknowledging the healing power of these events, assuaging fears of insanity, and helping the client stay within the experience. Drs. Silkworth and Tiebout provide admirable role models of this “being with” process.

5. Professional helpers have much to offer in the transition between the climactic TC experience and the consolidation of those changes into a new identity and lifestyle. One role is to help the individual construct a new narrative that guides how he/she relates to self and to others. There are also a variety of residual problems remain following a TC experience that may call for professional assistance. The therapy provided by Harry Tiebout and Frances Weekes during the 1940s for Bill Wilson’s bouts of depression illustrates the potential value of such assistance.

Processes of incremental and processes of transformational change may be analogous in terms of their long-term personal effects, but it is clear from this review that TC experiences have played important roles in the rise of therapeutic social movements. Charisma may be a lasting legacy of the TC experience and may explain why this atypical TC experience is overrepresented among leaders of recovery mutual aid and advocacy movements in the U.S. Therapists who respect the healing power of the TC experience can play supportive roles in such experiences and the movements that grow out of them.

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Citation: Published in revised form in White, W. (2004) The lessons of language: Historical perspectives on the rhetoric of addiction. In Tracy, S and Acker, S. Eds. Altering American Consciousness: Essays on the History of Alcohol and Drug Use in the United States, 1800-2000. Amherst: University of Massachusetts Press, pp. pp. 33-60. Posted at **www.williamwhitepapers.com**

The Lessons of Language:

Historical Perspectives on the Rhetoric of Addiction[1]

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The very naming of something creates new realities, new situations, and often new problems.

--Thomas D. Watts[2]

The first section of this paper provides a concise historical account of the evolution of the language used to label the excessive and problematic use of alcohol and other drugs in the United States. The account covers the birth of alcohol rhetoric, the extension of this rhetoric to encompass drugs other than alcohol, and the eventual extension of this language to include problems unrelated to drug use. This initial discussion will proceed with minimal references to the contextual forces that influenced this evolution of language. The second section of the paper, which attempts to analyze such contextual forces in some depth, argues that the confusion and conflict surrounding this evolving language stem from the multiple utilities that these words must successfully fulfill before coming into accepted use in personal, interpersonal, professional, political, and economic discourse.[3]

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[1] This paper is an expansion of the prologue of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Shortly after I began work on this book in 1994, Ron Roizen challenged me to carefully consider the language through which this story was to be told and suggested that the language was itself an important part of the history. Ron's role in initiating the inquiries that led to this paper is gratefully acknowledged.

[2] Watts, T. (1981). The Uneasy Triumph of a Concept: The "Disease" Conception of Alcoholism. *Journal of Drug Issues,* 11 (Fall): p. 451.

[3] This study includes some references to persons from other countries who exerted a profound influence on the way Americans perceived and labeled addictive disorders. The most significant of these external influences were

The Rhetoric of Addiction

The evolution of addiction rhetoric in America emerged out of what Harry Levine has called "the discovery of addiction"--a period in which those who consumed alcohol ceased being an homogenous group of "drinkers" and became separated into normal and abnormal drinkers.[4] The emergence of a new language to characterize and classify these differences marks the birth of American addiction rhetoric. This milestone was, as we shall see, followed by similar distinctions between those using medicines and those addicted to *drugs*.

Drinking and Drunkenness: Early Distinctions While the pervasiveness of alcohol and occasional drunkenness in colonial America is well indicated by Benjamin Franklin's treatise, *Drinker's Dictionary*, in which he defined some 235 terms to describe drinking, drinkers, and intoxication, there was no term other than *drunkenness* to describe the condition now known as alcoholism. It wasn't until per capita alcohol consumption began to rise dramatically between the Revolutionary War and 1830 that America began to look at excessive drinking in a new way and with a new language.[5] The harbinger of this new view came from an essay by the English physician, Thomas Trotter who referred to chronic drunkenness as a disease, and Dr. Benjamin Rush's 1784 American treatise *An Inquiry Into The Effects of Ardent Spirits Upon the Human Body and Mind, with an Account of the Means of Preventing and of the Remedies for Curing Them*. Rush's widely circulated pamphlet referenced the "habitual use of ardent spirits" and referred to such use as an "odious disease"--a phrase that perhaps marked a bridge between moral and medical conceptions of chronic drunkenness.[6] The Washingtonians, America's first society of recovered alcoholics, referred to themselves in the 1840s as *confirmed drinkers, drunkards, hard cases, inveterate cases, sots, tipplers*, and *inebriates.*[7] Concern about the stigma of such terms, however, led the Washingtonians to call their first residential care facility a "home for the fallen."

"Alcoholism" Coined The term *alcoholism* is of relatively recent origin. It wasn't until the eighteenth century that the word *alcohol* came to designate the intoxicating ingredient in liquor. The word itself derived from the Arabic word *al-kuhl*--a term first used for antimony-based eye cosmetic that later came to mean the essence or spirit of something.[8] The Swedish physician

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Dr. Thomas Trotter and Dr. Norman Kerr of England, Dr. Magnus Huss of Sweden, Dr. Albrecht Erlenmeyer of Germany.

[4] Levine, H. (1978). The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. *Journal of Studies on Alcohol*, 39(2):143-174.

[5] Historians variably place per capita alcohol consumption between 5-10 gallons but universally agree on these decades being the highest period in alcohol consumption in American history. Rorabaugh, J. (1979). *The Alcoholic Republic.* Oxford: Oxford University Press.

[6] Trotter, T. (1804) *Essay, Medical, Philosophical, and Chemical, on Drunkenness and its Effects on the Human Body*. (2nd Edition) London: Longman, Hurst, Rees, and Orme; Rush, B. (1810). Plan for an Asylum for Drunkards to be called the Sober House. Reprinted in: Corner, G. Ed. (1948). *The Autobiography of Benjamin Rush* Princeton: Princeton University Press; Rush, B. (1814) *An Inquiry into the Effect of Ardent Spirits upon the Human Body and Mind, with an Account of the Means of Preventing and of the Remedies for Curing Them.* (8th revised Edition). Brookfield: E. Merriam & Co. (Reprinted in Grob, G. Ed. (1981) *Nineteenth-Century Medical Attitudes Toward Alcoholic Addiction*. New York: Arno Press.)

[7] Baker, J. (1844). The Washingtonian Reform: An Address Delivered Before the Hingham Total Abstinence Society June 16, 1844. Published by the Society, pp.1-20; Wilkerson, A. (1966). *A History of the Concept of Alcoholism as a Disease*, DSW dissertation, University of Pennsylvania, p. 90.

[8] Lucia, S. (1963). The Antiquity of Alcohol in Diet and Medicine. In: Lucia, S., Ed., *Alcohol and Civilization.* New York: McGraw-Hill Book Company, Inc., p. 171.

Magnus Huss introduced the term *alcoholism* in 1849 to describe a state of chronic alcohol intoxication that was characterized by severe physical pathology and disruption of social functioning. His new term was intended to replace the German term *methylism* that Huss judged to be both obscure and technically incorrect.[9] It took nearly a century for Huss's new term, and the accompanying term *alcoholic*, to achieve widespread usage in America.

The Inebriate Asylum Era In the years following Huss's introduction of the term *alcoholism*, other terms emerged for consideration in professional and lay circles to describe the pathological craving for alcohol and the consequences of its excessive use. Dr. Norman Kerr, a prominent nineteenth century addiction expert, expressed a preference for the term *narcomania* or *intoxication mania*. Kerr chose these terms in the belief that the focal point of the compulsion was the state of intoxication rather than the intoxicating agent.[10] Before the term *alcoholism* became popular, terms such as *intemperance, barrel fever, habitual drunkenness (drunkard), dipsomania (dipsomaniac), inebriety or ebriosity (inebriate), victim of drink* and the *liquor habit* continued to dominate cultural and professional discourse in the late nineteenth and early twentieth centuries. Harry Levine, whose research traces the historical evolution of the American language used to label the alcoholic during this period, noted the following additional terms in popular use: *drunk, boozer, alcoholist, rum-sucker, stiff, rummy, souse*, and, *wino.*[11] The two terms most frequently used to refer to alcoholism at the end of the nineteenth century were *dipsomania* and *inebriety*.

The term *dipsomania*, taken from the Greek meaning "thirst frenzy," was introduced in 1819 by Christopher Wilhelm Hufeland[12]. Dipsomania came to be associated with a pattern of binge drinking characterized by periods of abstinence followed by what were sometimes called "drink storms." This pattern of explosive drinking was also christened *Oinomania* by the Italian physician Salvatori--a term drawn from the word *oinis*, meaning wine.[13] Esquirol in 1838 described dipsomania as a “monomania of drunkenness.”[14] Texts such as Wright's 1885 *Inebriism: Pathological and Psychological Study* used the terms *dipsomania* and *oinomania* interchangeably to characterize "an insatiable desire for intoxication."[15] *Dipso* (meaning alcoholic) and *dip shop* (meaning inebriate sanatarium) were common slang terms among the affluent during the early twentieth century.[16]

Inebriety, derived from the Latin root *inebriare*--meaning, to intoxicate--was a generic term for what today would be called *addiction* or *chemical dependency.*[17] Kerr defined *inebriety* in 1894 as a constitutional disease of the nervous system which was characterized by a morbid craving for intoxication.[18] The term encompassed a wide variety of choices of intoxicants. The

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[9] Sournia, J. (1990). *A History of Alcoholism.* Cambridge, MA: Basil Blackwell, Inc.

[10] Kerr, N. (1889). *Inebriety or Narcomania: It's Etiology, Pathology, Treatment and Jurisprudence*. New York: J. Selwin Tait & Sons.

[11] Levine, H. (1981). The Vocabulary of Drunkenness. *Journal of Studies on Alcohol*, 42(11):1046.

[12] Marconi, J. (1959). The Concept of Alcoholism. *Quarterly Journal of Studies on Alcohol*, 20(2):216-235.

[13] Wilkerson, 1966, pp. 65-66.

[14] Cited in: Marconi, 1959, p. 225.

[15] Wright, T. (1885.) *Inebriism: Pathological and Psychological Study.* Columbus, Ohio: William G. Hubbard.

[16] Johnson, 1959, p. 473.

[17] Bynum, W. (1968). Chronic Alcoholism in the First Half of the 19th Century. *Bulletin of the History of Medicine*, 42:161.

[18] Kerr, 1894, 3rd Edition, p. 41.

type of inebriety was specified in speech or writing, as in *alcohol inebriety*, or *cocaine inebriety*. The term inebriety gained prominence through the professionalization of addiction treatment homes and asylums via the American Association for the Study and Cure of Inebriety in 1870 and the founding of the *Quarterly Journal of Inebriety* in 1877.[19]

Alcohol inebriety seems to have encompassed more common forms of chronic drunkenness while the term *dipsomania* was a more medicalized term for episodic but explosive drinking binges that were thought to be a special form of temporary insanity. The term *inebriety* fell out of favor following the repeal of Prohibition, perhaps in part because the term embraced within its singular linguistic embrace good drugs that were to become celebrated and bad drugs that were to become increasingly demonized. The differentiation between alcohol language and "drug" language begins to become solidified in this post-repeal period. In our continuing story, we will first explore how alcohol language continued to evolve and then we will return to look at the rhetoric that emerged to depict addiction to drugs other than alcohol.

Psychiatric and Lay Therapy Influences Huss's term, *alcoholism*, gradually began to replace *inebriety*, first in professional circles and then in popular usage. This new term began to appear in American professional literature during the latter half of the nineteenth century, such as in Hubbard's 1881 treatise *The Opium Habit and Alcoholism* and in articles appearing in such journals as the *Medical Record* and the *Quarterly Journal of Inebriety.*[20] The modern professional shift to the use of the term *alcoholism* seems to have been marked by Karl Abraham's 1908 essay on psychoanalytic perspectives on the disorder.[21] Abraham was one of the first persons of national medical prominence to embrace the terms *alcoholism* and *alcoholic*. The lay therapists Ray Baker and Richard Peabody, and Charles Towns, proprietor of a well-known "drying out" hospital, were the first prominent treatment specialists to begin use of these twin terms in early twentieth century writings aimed at the general public.[22]

Consensus on the public and professional language to be used in defining problems with alcohol was slow in coming. The terms *alcoholism* and *alcoholic*, while increasingly utilized within the arcane literature of psychoanalysis by 1930, had still gained little popular usage. Charles Towns retreated from his earlier advocacy for the term alcoholic and expressed instead his preference for the term *alcoholic excessivist.*[23] A number of authors, including Dr. Robert Fleming of Boston, revived Huss's label *chronic alcoholism* and injected use of the term in the mainstream medical press.[24] Chronic alcoholics who clogged the courts of this period were christened *old rounders*.[25] At this same time, Charles Durfee, another addiction expert, attempted to popularize the terms *problem drinking* and *problem drinker*. Durfee preferred

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[19] Crothers, T.D. (1893). *The Disease of Inebriety from Alcohol, Opium and Other Narcotic Drugs: Its Etiology, Pathology, Treatment and Medico-legal Relations.* New York: E.B. Treat, Publisher.

[20] Douglas, C. (1900). Historical Notes on the Sanitorium Treatment of Alcoholism. *Medical Record* 57: 410-411.

[21] Abraham, K. (1927). *Selected Papers on Psychoanalysis*. London: Hogarth Press.

[22] Towns, C. (1915, 1920). *Habits that Handicap: The Menace of Opium, Alcohol, Tobacco, and the Remedy*. New York: Funk & Wagnalls Company.

[23] Towns, C. (1931.) *Reclaiming the Drinker.* New York: Barnes & Company, p. 58; Towns, C. (1932) *Drug and Alcohol Sickness*. New York: M.M. Barbour Co.

[24] Fleming, R. (1937). The Treatment of Chronic Alcoholism. *New England Journal of Medicine,* 217: 779-783.

[25] Anderson, V. (1916). The Alcoholic as Seen in Court. *Boston Medical and Surgical Journal*, 74:492-495.

these terms on the grounds that the term *alcoholism* was stigmatizing and because of his belief that alcohol was a problem for many people who were not diagnosable as alcoholic.[26] The founding of Alcoholics Anonymous did much to solidify use of the term alcoholism and bring it into widespread popular use, but even in the "Big Book" of A.A., one finds the terms *problem drinker* and *abnormal drinker.*[27] In 1938, Dr. Robert Seliger uses terms such as *problem drinker, uncontrolled drinker, spree drinker*, and *pathological drinker* interchangeably with the term *alcoholic.*[28] The term *alcoholism* was used frequently enough in the popular and professional press in the late 1930s that Dr. Edward Strecker and Francis Chambers complained that the term *alcoholism* had become as meaningless as the nineteenth century terms *nervous breakdown* and *feminine vapors*. They recommended use of the terms *normal drinker* and *abnormal drinker*.[29] In 1942, Dwight Anderson backed Durfee's use of the term *problem drinker* and further suggested that *malady* or *ailment* were preferable to *disease* given that the latter term was usually associated with conditions that had a physical rather than emotional basis. Anderson made a fine distinction in refusing to characterize alcoholism as a *disease* while referring to it as a *sickness*. He further emphasized the importance of the language debate by noting, "If the problem drinker is sick, as is agreed by most authorities, we should avoid terms which are incompatible with this idea."[30]

The Modern Alcoholism Movement The rise of the "the modern alcoholism movement" in the 1940s under the leadership of the National Committee on Education on Alcoholism (NCEA), firmly imbedded the terms *alcoholism* and *alcoholic* into scientific and popular use but did not stop the language debate. The NCEA successfully pushed these terms to the fore in spite of some reluctance from other quarters of the movement. Bruce Johnson, in his oft-cited study of the unfolding of the modern alcoholism movement, notes that many early leaders of this movement had misgivings about the term *alcoholism*. E.M. Jellinek, universally considered the modern godfather of the disease concept of alcoholism, actually preferred the phrases *abnormal drinking*, *alcohol addiction* or *compulsive drinking.*[31] Even when Jellinek came to reluctantly use the term *alcoholism*, his definition of it evolved significantly over the course of his career.[32] As early as 1941, Jellinek rejected the notion of a singular clinical picture of alcoholism and described fourteen distinct types of abnormal drinkers.[33] He defined as diseases only those types that exhibited "loss of control," but later added to the definitional confusion by dramatically expanding his definition of alcoholism. In 1949, Seldon Bacon warned that the over-application of the term *alcoholism* was creating a group of "Quasi Alcoholics" whose drinking presented problems for the community but who were hardly appropriate for alcoholism treatment. Included in this category were problem drinkers who were feebleminded, psychotic, or who had severe personality disorders. Bacon referred to

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[26] Durfee, C. (1937). *To Drink or Not to Drink*. Boston: Longmans, Green; Durfee, C. (1938). Re-Education of the Problem Drinker. *Journal of the Connecticut Medical Society*, 2:486.

[27] *Alcoholics Anonymous*. (1955). New York City: Alcoholics Anonymous World Services, Inc. p.18.

[28] Seliger, R. (1938). The Alcoholic in the Community. *American Journal of Psychiatry,* 95:701-716.

[29] Strecker, E. and Chambers, F. (1938). *Alcohol: One Man's Meat*. New York: The MacMillan Company, p. 21.

[30] Anderson, D. (1942). Alcohol and Public Opinion. *Quarterly Journal of Studies on Alcohol* 3(3): 389.

[31] Johnson, 1959, pp. 243, 293.

[32] Jellinek, E.M., Ed., (1942). *Alcohol Addiction and Chronic Alcoholism.* New Haven: Yale University Press; Jellinek, E.M. (1960). *The Disease Concept of Alcoholism*. Highland Park, New Jersey: Hillhouse.

[33] Bowman, K. and Jellinek, E. (1941). Alcohol Addiction and Its Treatment. *Quarterly Journal of Studies on Alcohol,* 2:98-176 (September); Jellinek, 1942, pp. 38-42.

these collectively not as alcoholics, but as "chronic social-misfit drinkers."[34] Mark Keller later concurred with Bacon that the term *alcoholism* was destroyed by its popularization during this period. He believed that its embrace by the culture as a whole softened and extended its meaning, thus destroying its utility as a technical and diagnostic term.[35]

The language debate didn't end with the popularization of the term *alcoholism* in the 1940s. Those treating alcoholics continued to struggle to forge a language with clinical utility, but this in itself created problems. In 1955, Dr. Ruth Fox noted the confusion over such terms as *situational drinker*, *symptomatic drinker*, *regular (or irregular) symptomatic excessive drinker*, *primary addict* and *secondary addict.*[36] Two years later, the World Health Organization (WHO), agreeing with Strecker, Chambers, Bacon and Keller that *alcoholism* had lost its clinical specificity, proposed use of the term *alcohol dependence* and further struggled to delineate application of the terms *addiction* and *habituation*. (This action of the WHO marked the rebirth of attempts to generate language that could apply equally to alcohol, opiates, cocaine, and other drugs.) In 1960, Jellinek underscored this linguistic problem by noting the existence of more than 200 definitions of *alcoholism*. After first offering an expansion of his own earlier definition of alcoholism, he tried to recapture the term's specificity by referring to "alcoholisms" and by reducing the historical body of literature on clinical subpopulations of alcoholics into his five "species" of alcoholism, each of which he designated with a Greek letter.[37] Others later followed Jellinek's lead in distinguishing types of alcoholism, using such distinguishing adjectives as "true/reactive," "primary/secondary," "Type I (milieu limited)/Type II (male limited)," "Type A/Type B," and "Appollonian/Dionysian." [38] [39]

Consensus was not to be achieved on use of the term alcoholism. At the end of a five-year research project in the 1960s, members of the Cooperative Commission on the Study of Alcoholism were still arguing over whether *person with a drinking problem* was preferable language to the term *alcoholic*. In 1967, they settled on use of the term *problem drinker.*[40] During this same period, the American Psychiatric Association (APA) jumped into the fray recommending the term *alcoholic problems*. It was the APA's position that the terms *alcoholic* and *alcoholism* created the stereotype that all persons with problems related to alcohol consumption suffered from a singular affliction. Some medical groups in the 1970s attacked the term *alcoholism* on the grounds that it was a term based on stereotype and biased

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[34] Bacon, S. (1949). The Administration of Alcoholism Rehabilitation Programs *Quarterly Journal of Studies on Alcohol*, 10(1):8.

[35] Keller, M. (1982). On Defining Alcoholism: With Comment on Some Other Relevant Words. In: Gomberg, L., White, H. and Carpenter, J. *Alcohol, Science and Society Revisited*. Ann Arbor: The University of Michigan Press, p. 123.

[36] Fox, R. And Lyon, P. (1955). *Alcoholism: Its Scope, Cause and Treatment*. New York: Random House.

[37] Jellinek, 1960, pp. 35-41.

[38] Babor, T. (1996). The Classification of Alcoholics: Typology Theories from the 19th Century to the Present. *Alcohol Health & Research World*, 20(1):6-14.

[39]William Rohan later attacked the creation of "alcoholisms" on the grounds that it multiplied rather than discarded a mistaken concept. He called alcoholism a "reified abstract noun" that had contributed to the field's "conceptual mess." Rohan W. (1982) The Concept of Alcoholism: Assumptions and Issue. In: Pattison, E, and Kaufman, E. *Encyclopedic Handbook of Alcoholism.* New York: Gardern Press, pp.31-39.

[40] Plaut, T. (1967). *Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism*. New York: Oxford University Press.

judgment. There were even proposals that the term *alcoholism* be dropped from usage completely and be replaced with the label *Jellinek's Disease.*[41]

When a national institute was established in the early 1970s with the phrase *alcohol abuse* in its title, the semantic battle intensified. Some sought to define *abuse* based on the circumstances of use (non-medical use), while others tried to define *abuse* based on the consequences of use (harm to the user or society). Mark Keller described *alcohol abuse* as "opprobrious, vindictive, pejorative" and an "inherently nasty" phrase.[42] [43] Other terms that could be found within the field's discourse during the 1970s included *problematic alcohol use, alcohol misuse*, *deviant drinking*, and *excessive drinking*. The National Council on Alcoholism took a step in 1972 to restore some clarity to this debate by publishing its "Criteria for the Diagnosis of Alcoholism." But major players in the health care arena continued to note the lack of operational definitions governing the alcoholism arena. The World Health Organization in 1974 characterized the situation as follows:

> *It is clear from a review of the responses to the WHO inquiry that there is no internationally or even nationally accepted definition of "alcoholism" or of "problem drinking" but that a variety of definitions and classifications are in use for legal, insurance, treatment, and research purposes*.[44]

Impact of Modern Diagnostic Classifications The continued language debate is most evident in the two modern systems of Diagnostic classification--the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association and the International Classification of Diseases (ICD) of the World Health Organization. "Alcoholism" first (1952) appeared in these evolving classifications as a subset of personality disorders and neuroses. This reflected the view that alcoholism was not a primary disorder but a symptom of underlying psychiatric illness. This stance was later (1980) abandoned in favor of two new independent classifications: *alcohol abuse* and *alcohol dependence*. The American Psychiatric Association in its latest (1994) diagnostic classification manual includes generic categories of *substance intoxication*, *substance dependence*, and *substance-induced disorders*, as well as more drug specific diagnoses such as *alcohol dependence*.[45] These

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[41] Jellinek's Disease, (1974) *AA Grapevine*, 31(4):42 (September); Fitzgerald, K. (1983). Living with Jellinek's Disease. *Newsweek,* October 17, p. 22.

[42] Keller, 1982, p. 129-130.

[43] Early applications of the word "abuse" to excessive alcohol and other drug use include Lender's discovery of one Joseph Birch who was fined and forced to "sit in stocks" for "abusing himself by drinking." (Lender, M. (1973) Drunkenness as an Offense in Early New England: A Study of Puritan Attitudes. *Quarterly Journal of Studies on Alcohol,* 34:p. 362) An 1830s letter sent by temperance reformer Edward Delevan to the students at Union College implored: "There can be no expediency to the use of a bad thing. All use of alcohol as a beverage, in my opinion is evil and evil continually....All use is abuse." Quoted in: Steinsapir,C. (1983) *The Ante-Bellum Total Abstinence Movement at the Local Level: A Case Study of Schenectady, New York,* PhD Dissertation, Rutgers University, p. 101.

[44] Moser, J. (1974). Problems and Programmes Related to Alcohol and Drug Dependence in 33 Countries. Geneva: World Health Organization, p. 9.

[45] American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (Fourth Edition): Washington, D.C., pp175-272; see also: Schuckit, M..; Nathan, P.; Helzer, J.; Woody, G.; And Crowley, T. (1991) Evolution of The DSM Diagnostic Criteria for Alcoholism. *Alcohol Health and Research World,* 15(4):278-283.

modern diagnostic systems were, in part, an effort to reflect the growing recognition that alcohol-related problems can exist in the absence of alcohol addiction.

In the late 1980s and early 1990s, the alcohol and drug addiction treatment industry was accused of ethical breaches involving the over-diagnosis of addiction-related disorders, modality misplacement, and clinically inappropriate lengths of stay in treatment. The industry needed some framework to re-instill diagnostic precision and credibility. The Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) was to a great extent developed in response to this need. The ASAM criteria replaced the 40-50 sets of criteria being used by insurers and utilization management companies to reduce inappropriate admissions and the propensity for treatment programs to place clients in a more restrictive and expensive modality than clinical characteristics warranted.[46]

Creating Language to Encompass Family Members During the 1980s, new terms were added to the professional jargon of addiction treatment that sought to capture the untoward effects of alcoholism on family members. Terms such as *co-alcoholism*, *para-alcoholism, child of an alcoholic* (COA), *adult child of an alcoholic* (ACOA), *dysfunctional family*, *enabler* and *codependency* were defined, redefined, over-used and misused.[47] This new language came under a flood of criticism following its invasion into the popular culture. The most severe criticisms were that the movement to expand the application of addiction language and concepts was nothing more than a commercially exploitive pseudo-science--a plethora of impressionistic descriptions of new pathologies that had no objective grounding in clinical research.[48] There was also a growing sense that terms like *codependency* and *dysfunctional* had become meaningless due to their indiscriminate and global application.[49]

Creating Language to Embrace Drugs other than Alcohol As if the language surrounding alcohol wasn't complex enough, the development of a professional language that could embrace the problematic use of drugs other than alcohol has been even more difficult in America. The evolution of this language has included nineteenth century terms named after the user's drug of choice: *narcomainia, methomania, vinomania, opiumism, opium drunkenness, morphinism, morphinomania, chloralism, narcotism* and *pharmacothymia*. The “ism” suffix generally referred to perpetual states of drinking or drug use; the “mania” suffix referred to the rabid craving that could incite periodic episodes of explosive binging. The latter term comes from the Greek word meaning madness[50]. Terms like *morphinist* and *opiophagist* were created to signal the addict’s drug choice and references to *drug drunkards* reflected attempts to apply alcohol language to other drugs.[51]

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[46] *Patient Placement Criteria for the Treatment of Substance-Related Disorders*. (Second Edition) (1996). Chevy Chase, Maryland: American Society of Addiction Medicine, Inc.

[47] Greenleaf, J. (1983). Co-Alcoholic...Para-Alcoholic...Who’s Who...and What’s the Difference. *Alcoholism: The National Magazine*, May-June, pp. 24-25.

[48] Gomberg, E. (1989). On Terms Used and Abused: The Concept of “Codependency.” In: Gomberg, E., Ed., *Current Issues in Alcohol/Drug Studies.* New York: Haworth.

[49] Scott, E. (1995). Abusing the Abuse. *Alcoholism Treatment Quarterly*, 13(3):6.

[50] Crothers, T.D. (1902). *Morphinism and Narcomanias from other Drugs.* Philadelphia: W.B. Saunders & Company.

[51] Whitaker, J. (1885) Cocaine in the Treatment of the Opium Habit. *Medical News*, August 8, p. 144; Greer, J., Albright, I.,and Smith, D.(1915) *Tragedies of the Opium Traffic*. Chicago: J. Regan & Co., Publishers.

There have also been attempts to create a generic term that would encompass multiple drug choices: *intoxicomania, narcomania, narcotoxia, drug addiction, drug habituation, drug compulsion, drug abuse, alcohol-and-other-drug-abuse, drug dependence, substance abuse, and chemical dependency*. Nearly all of these terms have come under episodic attack.[52] Concern with concurrent and sequential use of multiple drugs dates at least to nineteenth and early twentieth century inebriety literature in which we find such phrases as "mixed cases," "multiple inebriety," "combined inebriety," and "alternating inebriety."[53]

Three broadly encompassing terms have vied for modern prominence. The term *substance abuse* --an extension of the 1960's term "drug abuse" gained some prominence when both clinical data and economic necessity brought the merger of a growing number of alcoholism treatment and drug abuse treatment programs. A variant of substance abuse was the phrase *alcohol, tobacco and other drug* (ATOD) *use/abuse*. The inclusion of the word abuse in these phrases came under considerable attack for its abstractness and for its implied moralism. Jay Renaud went so far as to suggest that use of the term *substance abuse* was an abuse of language that "perpetuates ignorant and moralistic attitudes toward people with chemical dependency." In Reanud's view, references to substance abuse and substance abusers "paint these ill people as perpetrators, not victims."[54]

The term *chemical dependency* emerged within the "Minnesota Model" of alcoholism treatment practiced at Pioneer House, Hazelden, and Wilmar State Hospital in Minnesota. The term emerged to conceptualize the pattern of multiple drug use increasingly being seen at these facilities in the late 1950s.[55] This term spread as part of the wider incorporation of the Minnesota Model into a growing number of private and hospital-based treatment programs in the 1970s and 1980s but never achieved universal usage. As more medical and biological models for conceptualizing alcohol and other drug problems emerged in the 1980s, the term *addiction* vied for professional and popular dominance.

Addiction, derived from the Latin root *addicere* meaning to adore or to surrender oneself to a master, has risen in popularity during the last decade. If the term *addiction* has a certain mustiness about it, it's because it first came into common usage in the professional literature of the mid-1890s--the same period the term *dope fiend* was coming into common slang usage as a result of its repeated appearance in newspapers and magazines.[56] The term *addict*, or on

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[52] Wilner, D. And Kassebaum, G. (1965). *Narcotics.* New York: McGraw-Hill Book Company, p. 54.

[53] Remarks on Cocaine and the So-Called Cocaine Habit (1886). *Journal of Nervous and Mental Disease*, 13:754-759; Mattison, J. (1883). Opium Addicts among Medical Men. *Medical Record*, 23:621-623; Rogers, A. (1913). Some Observations during Eighteen Years' Experience with Drug and Liquor Habitues. *Wisconsin Medical Journal*, 12:43. (July).

[54] Renaud, J. (1989). Substance Abuse is Language Abuse. *The Counselor,* 7(4):26-27.

[55] One of the earliest references to advocacy of the term chemical dependency is a 1958 presentation by Jane Cain, a nurse at Dia Linn--Hazelden's treatment center for women. McElrath, D. (1987). *Hazelden: A Spiritual Odyssey*. Center City, Minnesota: Hazelden Foundation, p. 112.

[56] Origin and Meaning of the Word Addiction. (1936). *Scientific Temperance Journal*, Spring, p. 9. Mark Lender, in his research on the colonial management of drunkenness, discovered Puritan references to persons "addicted to" alcohol. Lender, 1973, p. 357. The term *dope*, which came into usage during this period, was first used to refer to any syrupy preparation and later came to designate products containing opium and cocaine. Persons ordering cocaine-laced soft drinks often simply said, "Gimme a dope." The changing view of drug use was reflected in the term *fiend* which is a German derivative that in its early use referred to a diabolically wicked and hated person (Ayto, 1990, p. 226). The first known appearance of the term "dope fiend" was in an 1896 article in the *New York*

occasion, *addictee*, emerged around 1910 to replace the earlier term, "habitué" used to designate a person suffering from an addiction.[57] Some addiction experts refused to use the term *addict* to apply to persons physically dependent upon narcotics because of disease or injury, but instead used the term only for those who developed "the habit" out of their search for pleasure.[58]

The resurgence of the term *addiction* has been accompanied by confusion between its scientific connotations and its popular usage.[59] Its precise scientific usage evolved out of the clinical observations of 19th and early 20th century treatment specialists through the more empirically oriented work conducted at the Addiction Research Center in Lexington, Kentucky in the 1930s and 1940s. Through these influences, *addiction* came to be defined as the presence of three conditions. To say that a drug was physically *addictive* or that one had *an addiction* required demonstration of: 1) increased tissue tolerance to the drug in question, 2) an identifiable and stereotyped withdrawal syndrome when use of the drug was interrupted, and 3) compulsive drug-seeking and drug-using behaviors in spite of adverse consequences. While these elements aptly describe what usually occurs through regular use of drugs such as heroin, there were other highly destructive patterns of drug use that did not necessarily show either tolerance or stereotyped withdrawal. This prompted respected specialists such as Dr. David Smith, founder of the Haight Ashbury Free Clinic, to suggest in the early 1980s a redefinition of the required elements of addiction to include compulsion, loss of control, and continued use in spite of adverse consequences.[60]

With the popularization of the term *alcoholism*, the words *addiction* and *addict* came to imply drugs other than alcohol, particularly the illicit drugs. But this distinction was not always clear. Some spoke and wrote of *addicts,* and encompassed alcoholics within the meaning of this term while others spoke of *alcoholics and addicts*. Early twentieth century references to the "drug evil" and to "drug peddlers" reflected the growing use of the term "drug" as a generic term to imply intoxicating and addicting substances. Pharmacy leaders waged an unsuccessful campaign to stop the use of the term "drug" in this manner within professional and popular literature.[61] The umbrella terms *narcotic* and *narcotic addiction* further added to the pollution of language when these terms came, through most of this century, to embrace cocaine, marihuana and other drugs whose psychopharmacological properties bore no resemblance to opiate drugs.[62] The American Medical Association's *Useful Drugs* even categorized alcohol as

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Sun. Hess, A. (1971) Deviance Theory and the History of Opiates. *The International Journal of the Addictions*, 6(4):593.

[57] Hickman, T. (1997). The Double Meaning of Addiction: Habitual Narcotic Use and the Logic of Professionalizing Medical Authority in the United States, 1900-1920. Presented at Historical Perspectives on Drug and Alcohol Use in American Society, 1800-1997, College of Physicians of Philadelphia, May 9-11, p. 6.

[58] Hubbard, S. (1920). Some Fallacies Regarding Narcotic Drug Addiction. *Journal of the American Medical Association,* 74:1439.

[59] Vogel, S. (1958). Psychiatric Treatment of Alcoholism. In: Bacon, S. *Understanding Alcoholism.* Philadelphia: The Annals of the American Academy of Political and Social Science, p. 99.

[60] Smith, D. (1984). Diagnostic, Treatment and Aftercare Approaches to Cocaine Abuse. *Journal of Substance Abuse Treatment,* Vol 1: pp5-9.

[61] Parascandola, J. (1996). The Drug Habit: The Association of the Word "Drug" with Abuse in American History. In: Porter, R. and Teich, M. *Drugs and Narcotics in History.* Melbourne, Australia: Cambridge, University Press, pp.156-167.

[62] The word *narcotic* is drawn from the Greek term *narke* meaning numbness.

a "narcotic" during the first half of this century.[63] What was included and excluded in the use of these terms became increasingly unclear and remains so.

A century-long thread has led to current efforts to define alcohol as a drug and to find an over-arching term that can conceptually embrace alcohol, tobacco and other psychoactive drugs.

From "Substances" to "Processes" The 1980s saw an extension of addiction concepts to behaviors unrelated to drug use. *Co-alcoholism* and *para-alcoholism* were expanded to *codependence* and then to a broad category of so-called "process addictions" that included destructive relationships with food, work, people, sex, gambling, shopping and religion. This was more than a conceptual and linguistic extension. Addiction treatment agencies began marketing products and services to persons involved in these other activities under the umbrella of addiction treatment. Defining the boundaries of the term *addiction* was an issue for the popular as well as professional worlds when people began referring to themselves as being *addicted* to everything from television to bowling. *Addiction* came to be used in the popular culture to refer to any behavior that was excessive, habitually repetitive, or problematic. People referred to themselves or others as chocaholics, workaholics, and various other "aholics." The skin of the addictions field split open, leaking its language and concepts into what became a passing phenomenon of American pop culture. For a brief period, it looked like all Americans were seeking "recovery."

Naming People, Helping Institutions and Naming Helping Interventions Through all of the eras reviewed in this paper, there has been disagreement about how to refer to persons who are undergoing treatment for addictive disorders. The terms *inmates, patients, clients, members, residents, guests*, and *students* have been the most common choices during the past century. There has also been an ongoing confusion within the field and the larger culture about what to call persons who are no longer actively addicted. (The necessity for such terminology is sparked, in part, by persons in stable recovery who continue to refer to themselves as alcoholics and addicts.) Debate over this designation has for the past 150 years included such labels as *redeemed (or repentant) drunkard*, *reformed drunkard, dry drunkard, dry (former) alcoholic*, *arrested alcoholic*, *ex-addict*, and the adjectives *cured, recovered*, and *recovering.*[64] The rather quaint term "Sobriate"--perhaps a takeoff on *inebriate*, was also used in some quarters to describe the recovered alcoholic.[65] Persons with prior histories of addiction are said variably to be *on the wagon*, *sober*, *drug-free*, *clean*, *straight, or abstinent*. There has

[63] Fishbein, M. (1932). *Fads and Quackery in Healing.* New York: Blue Ribbon Books, p. 285.

[64] A very animated debate continues over the terms recovered and recovering. While *recovering* conveys the dynamic, developmental process of addiction recovery, *recovered* provides a means of designating those who have achieved stable sobriety and better conveys the real hope of for a permanent resolution of addiction. Blume, S. (1977) Role of the Recovered Alcoholic in the Treatment of Alcoholism In: Kissin, B. and Beglieter, H., Eds., *The Biology of Alcoholism, Vol. 5, Treatment and Rehabilitation of the Chronic Alcoholic*, p. 546, New York: Plenum Press. James Royce criticized the use of "recovering" in 1986 on the grounds that the term implied that the alcoholic was still sick. He believed "recovering" should be used to designate only the earliest stages of alcoholism remission. Royce, J. (1986) Recovered vs. Recovering: What's the Difference? *The U.S. Journal* March, p.7. Testimony to just how far back this concern over language goes can be found in Harrison's 1860 report that the Washingtonian Society of Boston "fitted up rooms under their hall for the temporary accommodation of reformed, or rather, reforming, men." Harrison, D. (1860). *A Voice from the Washingtonian Home.* Boston: Redding & Company.

[65] *A History of Alcoholics Anonymous in Oregon: 1943-1983* Portland, Oregon: The Oregon Area General Service Committee of Alcoholics Anonymous, p. 39.

been no enduring consensus of what to call institutions that care for persons with alcohol and other drug problems. They have gone by such names as *home*, *asylum*, *reformatory*, *institute*, *sanatorium*, *sanatarium*, *hospital*, *ward*, *lodge*, *farm*, *retreat*, *agency*, *center* and *program*. There hasn't even been agreement on what to call what occurs inside these institutions: *reform, cure, rehabilitation, treatment, counseling, therapy*, and *reeducation.*[66] The trend has been to replace descriptive terms such as "caring for," "dealing with," and "helping," with medicalized terms such as "treatment" that convey the image of a more science-based intervention and attach a greater degree of professional prestige to the intervenor.[67]

Summary We have reviewed the struggle to achieve sustained medical and social consensus on 1) how to refer to persons whose alcohol and other drug consumption creates problems for themselves or society, 2) how to refer to people who are receiving some kind of intervention to correct these problems, 3) how to refer to this helping process, and 4) how to refer to people who once had, but no longer have, such problems. The review tends to confirm Ira Cusin's observation that *we keep tripping over the same old* (and, I would add, new) *words, loaded with connoatative effect, full of sound and fury, signifying nothing.*[68] In the next section, I will argue that this failed consensus on the rhetoric of addiction grew out of the multiple utilities such language must simultaneously serve.

Addiction Rhetoric and Its Multiple Utilities

In this section, I will offer some personal reflections on how the words selected to define alcohol and other drug problems reflect personal, social, political, economic, professional and clinical interests and must simultaneously meet needs in all of these zones of activity. I will suggest that the tensions that exist within and between these arenas have diminished, and will continue to diminish, the likelihood of American social and professional consensus on the language through which alcohol and other drugs problems will be framed.

Personal Utility The language used to label alcohol and other drug use provides a menu of symbols through which each individual can create, or make sense out of, his or her own relationship with these substances. Language can play a prohibiting, moderating, promoting, or transformative influence in the construction of this person-drug relationship. These labels, whether voluntarily embraced or forced on one from the larger society, may themselves affect the course of alcohol and other drug use and the course of any potential addiction and recovery process.

Let's consider several possible person-drug relationships and the kind of language needed to support each relationship. We first have people who have never used and do not wish to use alcohol and other traditionally defined drugs. By embracing a language that demonizes these substances and those who use them, non-users create distance between themselves and the problems such substances can cause. Language that evokes repugnance toward these drugs and their use can, in this way, serve as a personal preventative device. Using the

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[66] Several of these have interesting histories. *Cure*, derived from the Latin *cura*, came to mean "care" or "looking after." *Treat* and *treatment* came to imply "dealing with something by discussion," and "counsel" referred to the act of discussing or consulting. Ayto, (1990) pp. 133, 150, 527.

[67] Hiltner,S. (1964). Who Is Qualified to Treat the Alcoholic? Comment on the Krystal-Moore Discussion. *Quarterly Journal of Studies on Alcohol*, 25:354.

[68] Quoted in: Watts, 1981, p. 452.

defense mechanisms of reaction formation and projection, any latent curiosity or attraction to these substances is suppressed via an exaggerated animosity toward the substances and those who use them. These same mechanisms may be used by persons who experienced problems with alcohol or other drugs, aborted their pattern of use, and subsequently speak with great passion and animus against the drugs and those who use them.

A second group of people are those who use alcohol or other drugs without significant problems associated with such use. These individuals need a language that simultaneously affirms the legitimacy of their own use and helps contain their use within certain defined limits. This is done by a language that depicts when the line demarcating abnormal use is crossed. Where language serves as a preventative device in our first group, language serves as a rationalizing and moderating influence in our second group. Christie and Bruun noted this potential effect as early as 1969 when they attacked the use of words like *alcoholism* as devices used by "good drinkers" to separate themselves from "bad drinkers" so that the former could drink in guilt-free enjoyment while looking down upon the latter.[69] Language that defines drunkenness as a "vice" can bolster one's resolve to not drink in the same manner that language implying that alcoholism is a "disease" experienced by only a small number of drinkers can provide a rationale for continued drinking for those who don't perceive themselves as part of that vulnerable minority. Both types of language serve to create psychological distance between oneself and the degenerate or diseased other. Similar mechanisms operate within the American illicit drug culture. Persons who see themselves as responsible users, develop intracultural language that stigmatizes certain drug choices or patterns of use, as in the self-righteous castigation of phencyclidine (PCP) as "dummy dust."

A third group are those persons experiencing varying degrees of problems related to their alcohol or other drug use. Some members of this group want more than anything in the world to continue their alcohol or other drug use. Be evoking extreme caricatures via terms like "wino" or "dope fiend," these users can sustain the delusion that their own use, by comparison with such caricatures, is in control and not a problem or, later, a "little" problem but not a "serious" problem. (It is interesting that the psychological needs of both radical abstainers and addicts are met via such linguistic caricatures.) There is also a point at which chronic users may openly embrace such terms as "dope fiend" or "freak" to mock society's efforts to stigmatize them. Embracing such a stigmatized label can mark a significant "career milestone" in one's isolation and alienation from the larger society and one's engagement in a deviant and subterranean culture of addiction.[70]

There are also persons who are in agonizing physical and psychological pain and are in a desperate search for a way out of the addiction labyrinth. Such individuals need a language that enhances problem identification and resolution. They need a language that labels and confirms their experience, provides a face-saving means of understanding what happened to them, and points a hopeful direction for the future. Here language becomes, not a preventative or moderating influence, but a catalytic aid to personal transformation. Certain words can serve as keys to unlock frozen, compulsive patterns of drug use. The words that possess such face-saving and transformative power, however, vary from individual to individual and from culture

[69] Christie, N. and Bruun, K. (1969). Alcohol Problems: The Conceptual Framework. In: Keller, M. and Coffey, T., Eds., *Proceedings of the 28th International Congress on Alcohol and Alcoholism*, Volume 2. Highland Park, NJ: Hillhouse Press, p. 69.

[70] White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, MN: Hazelden.

to culture. The label “alcoholism” and the view of alcoholism as a “disease” may serve as a powerful face-saving and sense-making device for one individual while having little meaning to another person who may respond more powerfully to the construction of alcoholism as a “tool of genocide.” It is not necessary for language to be scientifically “true” to serve this catalytic function, but it must be metaphorically and emotionally true to the addict and his or her family. The language must also be culturally true in that it allows the addict and his or her family to construct a life story and a sobriety-based identity within the cultural context in which they live. A practical implication of this understanding involves the need for addiction treatment agencies to provide within their treatment milieus a broad menu of words, metaphors and rituals reflecting the diversity of their clientele. The diversity of drug users, the diversity of drug experiences, and the nesting of drug addiction within diverse family and cultural contexts make it highly unlikely that a narrow, highly codified language will emerge to perform this face-saving and sense-making function. In the end, it is personal and cultural viability, not scientific validity, that determines the power of language to incite and solidify the process of addiction recovery.[71]

The traditional therapeutic community perhaps more than any other addiction treatment modality is based on the power of language to shape identity and behavior. When Charles Dederich, the founder of Synanon, was once asked how he had organized hundreds of drug addicts into a self-directed therapeutic community, he responded simply, “It’s all done with words.”

The extent to which our culture has embraced various terms to describe alcohol- and other drug-related problems has been shaped in part by the degree to which each of these terms could help individuals in the culture banish or make sense out of the role of alcohol and other drugs in their lives. All future language choices will face this same test. The progression of addiction and the stages of recovery involve not only biological processes but a progression of other-applied and self-applied labels.

Social and Political Utility The language of addiction has meaning for abstainers, users, addicts and recovering addicts as they interact in their social worlds. In this way, words move beyond personal meaning and take on shared meaning for larger groups of people. Let’s consider what this means for addicts and recovering addicts. Many addicts are enmeshed in drug-using subcultures filled with an elaborate argot that reinforces their drug use and their affiliation with the culture of addiction. This argot not only separates insiders from outsiders, but establishes the elaborate pecking order within the drug culture. Consider for example Lindesmith’s story of an early twentieth century patron of an opium den who, upon finding someone injecting heroin in the bathroom, indignantly reported to the proprietor that there was a “god damned dope fiend in the can” and demanded his expulsion.[72] More recently, language has helped stratify the illicit narcotics subculture from the “righteous dope fiend” to the “gutter hyp” and all points in between.

In a similar manner, the way many persons disengage from addiction and the subculture in which it is nested is through a period of equal enmeshment in a language-rich culture of recovery. This recovery culture, whether in the form of Alcoholics Anonymous, Women for Sobriety or the Nation of Islam, provides a new language through which one’s past history is

[71] Conrad, P. And Schneider, J. (1980) *Deviance and Medicalization: From Badness to Sickness*. St. Louis: The C.V. Mosby Company, p. 85.

[72] Lindesmith, A. (1947). *Opiate Addiction*. Bloomington, IN: Principia Press, Inc., p.187.

understood and one's identity and lifestyle are reconstructed. This new language has not only personal utility but social utility. It is a way to become fully involved in a new social world. The language of addiction must meet the needs of a large group of recovering addicts within our society. What the growing diversity of sobriety-based support structures share in common is an internally shared and rich language to frame the past and shape the on-going recovery process.[73]

The social and political utilities that must be achieved in the linguistic construction of the "alcohol problem" or "drug problem" include defining and responding to deviance in a way that promotes social order and the interests of existing social institutions. While there may be pendulum swings between medicalization and criminalization of excessive psychoactive drug consumption and its accompanying sets of language, conceptualizing change within such a dichotomy overlooks the reality that medicalization and criminalization nearly always co-exist and that both of these responses are methods of social control. While criminalization may be more personally or socially stigmatizing than medicalization, both processes seek to alter the targeted behavior in ways that enhance social order. Both serve hiding functions through the isolation and pressured sequestration of the addict. Extreme pushes for medicalization and seemingly opposite pushes for criminalization both serve as powerful homeostatic devices that support social order. It is within the legal arena that this definitional process most specifically serves this function by reconciling notions of disease with those of personal freedom, insanity, and criminal responsibility.[74]

The language of addiction also serves a symbolic function in social intercourse. This language might be said to be "coded" in that it is filled with covert, as well as overt, meanings. Each word within the addiction vocabulary can signal a much broader set of values and a broader world view. Each word has socially symbolic as well as objective meaning. In this way, public surveys showing wide agreement with the proposition that alcoholism is a disease may not reflect knowledge about the biological etiology or course of alcoholism as much as it does the broader notion that alcoholics are in need of help and that public resources should be allocated to provide such assistance. Agreeing that alcoholism (as opposed to drunkenness) is a disease (rather than a vice) says more about ourselves and our social being than it does about the science of alcohol pathology. Pioneers within the "modern alcoholism movement" such as Dwight Anderson and Marty Mann, understood much more than the scientists with whom they worked, that the success of that movement hinged not so much on new scientific discoveries about alcoholism as on changing social perceptions of alcoholism and the alcoholic. Words and images, not scientific evidence, were the tools used to launch this social revolution. What the modern alcoholism movement brilliantly achieved was to make how one spoke about alcoholics a symbol of one's degree of personal compassion and social enlightenment.

The rhetoric chosen to define and discuss drug addiction has often vacillated between defining addicts as diseased patients in need of medical treatment and defining addicts as immoral, criminal deviants who require isolation, punishment and control. The language moves addicts within or outside our experience through the mechanism of social judgement. Language renders addicts within the boundary of "we" or projects them into the feared and hated world of "they." In more theological terms, language can transform one's contact with an

[73] White, 1996, pp. 51-53, 268-275.

[74] T.D. Crothers, in his 1893 treatise, *The Disease of Inebriety*, addresses several chapters to medico-legal questions raised by the conceptualization of inebriety as a disease.

addict from an “I-Thou” relationship to an “I-It” relationship. Language creates a cultural lens through which outsiders are stigmatized while insiders are excused for exhibiting precisely the same behavior. A person using narcotics prescribed by a doctor is a “patient” using “medicine;” a person using narcotics without a prescription is a “drug addict” or a “junkie” “strung out” on “dope.” The former is said to be “clean;” the latter is said to be “dirty.” The doctors and pharmacists who provide the narcotics to the former are “professional healers;” those providing the same narcotics to the latter are “pushers” and “predators.”[75]

America has long defined the ”drug habit” as evil, but has vacillated on the precise source of this evilness. Linguistic distinctions have helped sustain the logic that bad people (defined as people different from us) use drugs because of their inherent badness, whereas good people (people like us) use drugs because some evil force outside themselves overpowered their goodness. Our labels help distinguish between good and bad drugs and between good people who deserve our sympathy and professional assistance and bad people who should be isolated and punished. Such delineation is often dependent upon much broader political, economic and social forces. The transition in terms from *intemperance* to *inebriety* to *dipsomania* was, according to Sarah Tracy’s investigations, an evolution between the view of drunkenness as vice and drunkenness as medical disease. In the nineteenth century these terms were used simultaneously in ways that afforded both vice and disease views to co-exist with social class often determining which judgement and language was to be applied. The wealthy were likely to be viewed as suffering from the disease of dipsomania while their poorer brethren were likely to be viewed as suffering from the vice of willful drunkenness.[76] Motivation as well as social class influences such designations. Those seeking escape from pain are afforded some degree of sympathy in the labels applied to them while those viewed as seeking unearned pleasure through the medium of drug intoxication are subjected to the most pejorative labels.

When one examines the American rhetoric in which alcohol and other drug problems have been constructed, one is immediately struck by the fact that this rhetoric tends to become highly inflammatory during periods of great social conflict. The addiction rhetoric during these times is not so much about drugs as it is about groups of people linked to their use. Struggles between races and social classes and broader concerns about social disorder often get played out metaphorically in prohibitionist campaigns and “drug wars.” Racial, class and intergenerational conflict have exerted a profound influence on American addiction rhetoric. Such conflict birthed the “firewater myths” surrounding early Native American responses to distilled spirits. In the 1870s, it fueled the West coast anti-opium campaign with its inflammatory images of white children being seduced into Chinese laundries where they were forced to “yield up their virginal bodies to their maniacal yellow captors.” Nativism, immigration, racism, and social and class conflict enlarged that campaign and fueled the myth of “Yellow Peril”--the delusion that opium was being used as a political weapon to weaken America as the prelude to Chinese invasion of the United States. We see this pattern of inflammatory rhetoric continuing through the turn of the century anti-cocaine campaign with its images of cocaine-crazed black men attacking white women and rumors of cocaine-inspired black uprisings in the South. It continues with the alcohol prohibition forces tapping anti-

[75] White, W. (1979). Themes in Chemical Prohibition. *Drugs In Perspective*. Rockville, MD: National Drug Abuse Center / National Institute on Drug Abuse, p. 179.

[76] Tracy, S. (1992). *The Foxborough Experiment: Medicalizing Inebriety at the Massachusetts Hospital for Dipsomaniacs and Inebriates*. Ph.D. Dissertation. University of Pennsylvania, pp. 6,13,91.

Catholic and anti-German sentiment, the anti-marihuana campaign of the 1930s with its repeated references to cannabis inspired violence among Mexican-Americans, the 1950s accusations of communist involvement in American drug trafficking, and the intergenerational and racial underpinnings of the "war on drugs" campaigns of the last half of the twentieth century. We see here how an inflammatory addiction rhetoric is mobilized as a weapon in the struggles between groups of people--conflicts that are first and foremost not about rituals of psychoactive drug consumption or their associated problems. The rhetoric of addiction in these contexts serves the broader function of reflecting, fueling and sustaining these conflicts.[77]

The language of addiction might be compared to a projective word test revealing prominent or emerging features of the national temperament. Words move into and out of prominence as they reflect or fail to reflect the dominant emotion of the culture. Addiction rhetoric becomes more personalized and medicalized during periods of collective introspection and optimism—optimism about the power of our scientific technology and the potential for human transformation. Addiction rhetoric takes on moral and criminal connotations during periods of lost faith in ourselves and our technology and during periods of increased social disorder. Whether we use language that calls for toleration or language that calls for punishment says as much about our own collective temperament as it does about addicts and addiction. The cycles of addiction rhetoric involve competing, and sometimes alternating, patterns of language that evoke empathy and concern on the one hand and fear and aggression on the other. Science is not the driving force, but more often a self-absorbed bystander in the evolution of this language.

Professional Utility The rhetoric of addiction reviewed in this paper is also a means of staking out professional territory. It answers by implication what institutions and professional roles have legitimate ownership of the problem. There could have been no Inebriate asylums, no American Association for the Study and Cure of Inebriety, no *Quarterly Journal of Inebriety* without the concept of *inebriety*. By defining inebriety and declaring this condition a disease, problem ownership for alcohol and other drug problems shifted into a specialized arena. It shifted partial ownership for alcohol and other drug problems from the jails and psychiatric asylums--institutions that didn't particularly want ownership of the problem--and made a marginal peace with a temperance industry that wanted ownership of the problem but not those persons who were products of the problem.

In the case of the inebriate asylum era, there was more a coexistence within the dominant alcohol problem paradigm than a replacement of that paradigm. Inebriate asylum specialists didn't so much declare that inebriety was a disease rather than a vice as much as they said inebriety could be both a disease **and** a vice. In their vocal efforts to screen out hedonists, vicious criminals and the morally inferior, asylum managers reinforced the view that drunkenness was a function of weak moral character in some people. The delineation of which people suffered from the moral vice of drunkenness and which suffered from the disease of inebriety was based, as earlier noted, primarily upon ethnic and social class distinctions.

In this way, the new inebriety specialists found a way to escape the twin challenges of professional emergence: drawing one's arena large enough to procure the needed support and

[77] This role has been noted by nearly all those who have chronicled American drug use. Samples of the extremes reached in the use of this inflammatory rhetoric can be found in: Musto, D. (1973). *The American Disease: Origins of Narcotic Controls.* New Haven: Yale University Press, and Helmer, J. (1975). *Drugs and Minority Oppression.* New York: Seabury Press.

resources to sustain growth while not drawing the boundary so wide as to draw fire from more established and more powerful forces that exist on the field's perimeter. The question is how to emerge and justify one's existence without drawing lethal fire from other stakeholders in the problem to which one has laid claim. Language is an essential medium through which new professions stake their territorial claims. When inebriety was defined and declared a condition that could be a disease **and** a vice, the new inebriety specialists temporarily pacified powerful temperance forces. When they laid claim to dipsomania and defined it as a form of temporary insanity, they built a bridge to the alienist's (nineteenth century psychiatrists') view of addiction. But perhaps, most importantly, when they set forth the concept of inebriety as a primary disease requiring specialized treatment, they carved out a niche that formed the foundation of addiction treatment and today's field of addiction medicine.

While the codification of the language of discourse is an essential stage in the emergence of a new profession, the debate over such language can be quickly closed in ways that serve to suppress new research and new ideas.[78] This premature "hardening of the categories"[79] can lead to stagnation and provoke future ideological backlashes. The history of alcoholism treatment from 1940 to 1980 might be depicted as the emergence of a single-pathway model of understanding the etiology, course, treatment, and prognosis of alcoholism, with the years from 1980 to the present marked by professional and public backlash and the emergence of a multiple-pathway model of alcohol problems and alcoholism. The challenge is to construct alcohol and drug problems in a way that enhances professional identity and organizes professional activity, while not constructing that ideology so narrowly as to create stagnation and eventual implosion. This history suggests that professional language can reflect the suppression of science as much as the advancement of science. The images of a professional system defining itself so narrowly as to become professionally extinct or so broadly as to be devoured by neighboring professional arenas are provocative ones.

Language can not only create professions, it can help place those professions within a pecking order of prestige in relationship to other professions. This is particularly important when a new professional arena embraces issues, problems or persons who have been highly stigmatized. The new language must find ways to not only destigmatize those who have the maligned condition but to destigmatize those who choose to professionally work with that condition. The medicalization of language used to construct alcohol and other drug problems provided an esteem-salvaging legitimacy to those being treated **and** to those doing the treating.[80] Addiction had to be converted into a disease of complex pathology before "drunks" could be converted into "alcoholics" and rendered legitimate patients for the new physician specialty of addiction medicine. The medicalization of addiction was as much about the desired prestige of the caregivers as it was the destigamtization of alcohol and drug addicted patients.

By staking out new territory, language is essential to the emergence of new professions. By marking the boundaries of that professional territory, language defines the professional perimeters and the outside bodies with whom one must relate. By signaling insider or outsider status, language serves as a litmus test for membership within a professional arena and also

[78] Ron Roizen, Personal Communication, December 5, 1996.

[79] Underhill, F. (1961) Quoted in Toynbee, A. *Reconsiderations (A Case Study of History XII).* London: Oxford University, p. 1.

[80] The linguistic shift from GRID (Gay-Related Immune Deficiency) to AIDS (Acquired Immune Deficiency Syndrome) in 1982 marked a similar step in destigmatization effecting both persons with HIV/AIDS and their care givers. See Shilts, R. (1987). *And the Band Played On.* New York: St. Martin's Press, p. 71.

one's membership in various "schools" within that arena. In the case of professions related to alcohol and other drug problems, this professional language must also serve clinical and economic utilities.

Clinical Utility At a clinical level, language promises precision. It holds out the possibility for the scientific classification of addictive disorders and co-morbidities in ways that allow a careful matching of particular intervention technologies to the characteristics and needs of particular patients. And yet considerable struggle occurs at the boundary of such classifications. When the language of clinical diagnosis is drawn too narrowly, many persons who could benefit from available helping interventions are deprived access to such help. When the language of clinical diagnosis is drawn too broadly, there is the risk of people being subjected to voluntarily or involuntarily treatment who do not warrant such diagnosis or treatment.

The issue here is not simply that a few people may get unneeded but otherwise benign treatment, but that such misplaced treatment may do great harm. This harm can include the economic costs of unneeded or inappropriate treatment that a patient or family must bear, the harmful effects of having been labeled with a stigmatized condition, and the actual physical or psychological harm resulting from the treatment interventions--what in medicine are referred to as "iatrogenic illnesses" or "iatrogenic effects." It is thus language that defines the boundaries of competence separating fields of professional practice, defines which people will enter a particular arena, and what interventions they will be subjected to within that arena. The more life-threatening the conditions and the more invasive the potential procedures, the more crucial becomes the precision and application of this language.

There has always been in the addictions field a struggle between the desire for clinical precision (particularly in the arena of clinical research), the desire to satisfy the needs of other social institutions such as general and psychiatric hospitals and the courts, and the desire for expanding the field's own sphere of professional influence and economic advantage. Recently coined terms such as "checkbook diagnosis" reflect the way in which institutional greed corrupted much of the assessment procedures used by modern addiction treatment programs suffering from low patient census.

Another clinical use of language involves the link between the professional and public arenas, more specifically, communicating to the public in a manner that those suffering with a particular disorder will know how and where to seek appropriate assistance. When professional language is so technical and obscure that it surpasses common understanding, persons in need become vulnerable to charlatans who are successful in attracting those in need simply by virtue of the charlatan's ability to speak clearly, passionately and hopefully. A similar risk arises when professional language is corrupted by popular usage. When professional language is simplified and fully absorbed into the popular language, perceived distinctions between professional helper, folk healer, and scam artist disappear and those in need are at great risk of exploitation.

Economic Utility The language used to construct alcohol and other drug problems is also an economic commodity. It is a designator of who has problem ownership and any associated power and status, but also determines who shall receive the financial resources society has invested in managing the problem. Transforming "drunks" into diseased "alcoholics" created not only a new professional arena but also a new billable diagnosis and a new legitimized medical patient who could serve as a replacement for the diminishing raw materials (patients)

that fueled a hospital-based health care industry. Language is also a marketing commodity that determines, through how the problem is framed, the degree of comfort or resistance citizens will have seeking those services. Stigmatizing language ("drunkenness"), as an example, requires coercive tools of engagement, whereas a medicalized, face-saving language ("dipsomania," "alcoholism") holds out the opportunity for voluntary engagement. In a similar manner, language can dictate how much "treatment" can be sold. To pronounce a patient "recovered" after a brief course of inpatient or outpatient counseling communicates that treatment is over. Declaring that this same patient has finished his or her first "stage of treatment" as a "recovering" alcoholic or addict signals the existence of on-going needs to which the treatment institution may continue to market its products and services.

The economic value of language has important implications for boundary definitions of a professional field. Financial resources (and institutional and personal gain) expand to the extent that the definition of a disorder can be expanded to encompass a larger population. At the same time, such expansion poses the danger of increased conflict with allied professions and the risk of ethical breaches resulting from practicing beyond the limits of one's knowledge and skill. Such financially motivated over-extension, by publicly damaging professional credibility, can actually threaten the very future of a professional field. The shift to encompass a broad spectrum of alcohol problems within an alcohol addiction treatment industry, the further extension of that industry to encompass drugs other than alcohol, and the recent extension of the field to encompass "process addictions" stands as a clear example of such expansionism. The explosive growth of the "recovery" industry, the backlashes against industry breaches in ethical practice, and the resulting collapse of much of that industry collectively stand as a morality tale about the risk of a field moving beyond the boundaries of its competence.

Another category of financial stakeholders in the linguistic construction of alcohol and other drug problems includes those public and private institutions responsible for providing the funds that support addiction treatment services. Where private institutions such as insurance companies almost universally benefit (via reduced liability and increased profits) from a very narrow definition of billable diagnoses, federal and state governmental bodies charged with funding addiction treatment have quite mixed interests. Since the status of such agencies is often measured by overall budget and number of employees, an expansionist approach to the definition of alcohol and other drug problems often serves to enhance personal and institutional power. At the same time, units (such as medical directors or research departments) within these organizations often advocate very narrow and precise problem definitions. It has been my experience working within such organizations that they dynamically expand the defined scope of their arena until they encounter the boundaries of more powerful organizations within their operating environments.

There are other financial stakeholders in the debate over the language in which alcohol and other drug problems are constructed. Since the repeal of prohibition, the alcohol beverage industry has actively involved itself in professional dialogues regarding construction of alcohol-related problems. Their financial resources and political power have been used in an effort, more aptly described as haphazard than conspiratorial, to influence this problem construction debate in ways that protected their financial interests. This influence has included efforts to shape the language within which alcohol problems were to be constructed. The first evidence of this influence can be found in the heavy lobbying of alcohol industry representatives in the 1940s to get the Research Council on Problems of Alcohol to avoid using the term alcoholism.

Alcohol industry representatives preferred terms not named after their product (such as "problem drinking")--terms that shift the locus of the problem from alcohol to the drinker.[81]

While the alcohol beverage industry in the 1930s and 1940s did not like the term *alcoholism*, it was comfortable with the way in which Alcoholics Anonymous, the National Council on Alcoholism and the major public health institutions defined the totality of the alcohol problem in terms of a small percentage of drinkers whose physiological or psychological sensitivities prevented them from having a normal, healthy relationship with alcohol.[82] For the alcohol beverage industry, framing alcohol as an addictive poison or focusing on the misuse of alcohol by the majority have always been much more financially threatening conceptualizations of alcohol problems than defining such problems in terms of alcoholism. Alcoholism defines the problem inside the drinker and allows the industry to divert attention from the much broader and more pervasive problems created by their product--problems that have nothing to do with alcoholism as it has been medically defined. Both the licit alcohol and drug industries have a financial investment in linguistically framing America's alcohol and other drug problem in ways that separate those problems from their own products and promotional activities. Nowhere is this more evident than in the discomfort of the alcohol industry with the "alcohol is a drug" campaign and the prolonged machinations of the tobacco industry to avoid having their product labeled an "addictive drug."

The debate over the language in which alcohol and other drug problems is to be constructed is, at one of its most primitive levels, a fight about money. Nuances of ideological argument mask the fact that the outcome of this debate determines the future of industries, communities, and individual careers.

Prospects for the Future

The struggle to achieve consensus on an accepted language in which to frame alcohol- and other drug-related problems involves what are in all probability unresolvable problems. There are simply too many uses to which such language must be put to achieve a stable language. Language that offers clinical precision related to the diagnosis of addictive disorders severely limits the ability of these constructs to travel across demographic and cultural boundaries to serve as what Room has called a "governing image" for the society as a whole. The tension that exists within and between the personal, social, political, economic, professional and clinical utilities that the language of addiction must serve makes it likely that this language will continue to be a source of more confusion and conflict than consensus. Its continued evolution will mark the jockeying for power in the overlapping ownership of alcohol and other drug problems. Its continued evolution will also constitute a reflection of this culture's enduring ambivalence about psychoactive drug use.

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[81] Johnson, (1973); Wodak, A. (1995). The Language of Industry: Toward a Definition of Liquorspeak. *Addiction,* 90:133-134.

[82] Burnham, J. (1993). *Bad Habits: Drinking, Smoking, Taking Drugs, Gambling, Sexual Misbehavior, and Swearing in American History.* New York: New York University Press, pp. 81-85.



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Citation: White, W. (2004). Professional ethics. In R. Coombs (Ed.), *Addiction counseling review: Preparing for comprehensive certification exams*. Lahaska Press, pp. 535-576. Posted at **www.williamwhitepapers.com**

Professional Ethics

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Introduction

The goals of this chapter are to: 1) introduce you to some of the basic terms and concepts related to professional ethics in addiction counseling, 2) increase your ethical sensitivities by orienting you to the ethical terrain of addiction counseling, 3) enhance your ethical decision-making abilities through exposure to one model of ethical decision-making, and 4) provide you with guidelines about how to reduce your ethical vulnerability as an addictions counselor. I encourage you to apply the ethical standards of your own agency and your state certification/licensure board in your reflections on the dilemmas discussed in this chapter. Standards from two national bodies will be referenced in our discussions: NAADAC, The Association for Addiction Professional's ethical standards for counselors (www.naadac.org), and the International Certification & Reciprocity Consortium/Alcohol & Other Drug Abuse, Inc.'s (ICRC) codes of ethics for clinical supervisors and for prevention specialists (www.icrcaoda.org).

What do we mean when we use terms like "ethics" "ethical" and "unethical"?

There are many judgments that others can make about what you as an addictions counselor do or fail to do. A single act could be judged by others to be immoral, illegal, professionally inappropriate, or unethical, with each of these terms springing from very different frameworks of reference. Striving for a high level of ethical conduct is at its most aspirational level about *beneficence*—promoting the health of all parties touched by the counseling process. At its most basic level, it is about preventing harm to: 1) your clients/families, 2) yourself, 3) your agency, 4) your profession, 5) and your community. The best interests of these multiple parties can conflict within one another, which is what makes ethical decision-making difficult. Three terms help distinguish the ethical from other frameworks of judging professional conduct.

The first term, *iatrogenic,* is a medical term that means physician-caused, or treatment-caused, harm or injury. The term suggests that actions you initiate as an addictions counselor with the most noble of intentions could have unintended and harmful effects. In the past 200 years, there have been many such iatrogenic practices within addiction treatment: multi-year

legal commitments, mandatory sterilizations, invasive psychosurgeries, drug insults of numerous varieties (e.g., treating morphine addiction with cocaine), emotional and sexual exploitation of clients, and financial exploitation of clients and their families.

In professions where there is a potential for such harm, services to clients are delivered within the context of a *fiduciary relationship*. This means that as an addictions counselor, you take on a special duty and obligation for the care of the client/family, and that this relationship must be governed by the highest standards of competence and objectivity. Most importantly, it means that the needs and interests that drive decision-making in this relationship are those of the client/family. Unlike most other relationships in your life, the fiduciary relationship is not a relationship of equal power nor is it reciprocal like most family and social relationships. Everything you do as a counselor should flow out of this special duty and obligation.

Another term governing the relationship between you and your clients is that of *boundary*. Boundary management reflects the relative pace and degree of intimacy in your service relationship with a client. If we were to construct a continuum of intimacy within the relationship between yourself and your clients, three zones could be plotted: 1) a zone of safety for both you and your clients (actions that are always okay), 2) a zone of vulnerability in terms of increased attachment or disengagement (actions that are sometimes okay and sometimes not okay), and 3) a zone of abuse in terms of harmful intimacy or detachment (actions that are never okay) (Milgrom 1992). The boundaries between these zones are not well-marked and may vary with different clients and even with the same client at different stages of the service relationship.

What distinguishes what is ethical from what is legal?

Ideally, standards of legal and ethical conduct are congruent (what is ethical is also legal and what is unethical is also illegal). But the relationship between ethics and law is actually quite complex. There are situations in which: a) what is ethical is illegal (breaking an unjust law), b) what is unethical is legal (complying with an unjust law), and situations in which c) what is ethical or unethical is alegal (not addressed in law) (Thompson, 1990). The question of what is ethical or unethical is thus a more complicated issue than the question of what is legal or illegal. To rely only on the latter would constitute a process of legal reductionism that shrinks ethical complexities to the arena of legal interpretation. The best models of ethical decision-making integrate questions of ethics and law within the decision-making process.

What are the major zones of ethical vulnerability in the practice of addiction counseling?

A review of the two primary texts on ethical issues in addiction treatment (Bissell & Royce, 1987 and White & Popovits, 2001) reveal seven zones of vulnerability in the practice of addiction counseling: 1) personal conduct, 2) conduct related to business practices, 3) professional conduct unrelated to clinical services, 4) conduct in relationships with clients and families, 5) conduct in professional peer relationships, 6) conduct involving threats to safety, and 7) ethical issues in special roles/functions, e.g., prevention, early intervention, training, and research.

When examined in terms of their prevalence within the field of addiction counseling (as measured by complaints regarding ethical breaches filed with state licensing boards), the three most common complaints are sexual exploitation of a current client, personal impairment due to substance use or another condition, and practicing addiction counseling without a certificate (St. Germaine, 1997).

What factors must be considered in ethical decision-making?

There are many models of ethical decision-making that you might find helpful in your role as an addictions counselor (Wagner, 2001). The model proposed by myself and Renée Popovits (2002) involves three steps. The first step is to analyze the situation in terms of who will potentially benefit and who could potentially be harmed. This requires detailing both the probability and degree of benefit and harm to multiple parties. This first step also examines whose interests in the situation might be in conflict, e.g., what is best for the client in a particular situation may not be what is best for you or your agency.

The second step asks you to examine whether there are any universal or culturally-relevant values that apply to the situation, and what actions those values might dictate that you take in the situation (See table later in this chapter). The question of culturally-relevant values suggests that ethical standards might differ across different cultural contexts, e.g., that an action that could be beneficial in one cultural context might do harm or injury in another context.

The third step asks you to explore how existing ethical codes, laws, regulations, organizational policies or historical practices apply to the situation in question. This model provides a framework for individual decision-making, but also underscores the need for seeking consultation on ethical dilemmas.

What are the major codes of ethical conduct governing the practice of addiction counseling?

As an addictions counselor, you may be accountable to multiple codes of ethics. You may be bound by codes of ethics linked to a) national and/or state addictions counselor certification/licensure systems, b) state and national professional associations, e.g., NAADAC, c) professional licenses/certificates held in addition to addiction counseling, e.g., ethical codes for psychologists, social workers, professional counselors, employee or student assistance professionals, and d) agency codes of ethics that are a condition of your employment. The existence of multiple and qualitatively different standards to which you may be held accountable raises the question of which standards apply in particular situations. To afford the greatest protection for your clients, yourself, your employing agency, the addiction counseling profession and the public, it is generally best to be guided by the more stringent standard, except where the application of the more stringent standard would do harm to the client/family to whom we have pledged fiduciary responsibility.

What ethical principles underlie the practice of addiction counseling?

The codes of ethics that have evolved to guide the practice of addiction counseling draw heavily upon earlier traditions of ethical standards development in the fields of medicine, psychology and social work. Typical of the principles that undergird addiction counseling are the following twelve principles within the NAADAC Code of Ethics: 1) non-discrimination; 2) responsibility (for objectivity and integrity); (3) competence; (4) legal and moral standards; (5) public statements; (6) publication credit; (7) client welfare; (8) confidentiality; (9) client relationships; (10) interprofessional relationships; (11) remuneration; and (12) societal obligations (NAADAC, 1994).

The universal values considered within the White/Popovits (2001) model of ethical decision-making are displayed below.

Exhibit 10-A: Universal Professional Values*

Autonomy (Freedom over one's destiny)
Obedience (Obey legal and ethically permissible directives)
Conscientious Refusal (Disobey illegal or unethical directives)
Beneficence (Do good; help others)
Gratitude (Pass good along to others)
Competence (Be knowledgeable and skilled)
Justice (Be fair; distribute by merit)
Stewardship (Use resources wisely)
Honesty and Candor (Tell the truth)
Fidelity (Keep your promises)
Loyalty (Don't abandon)
Diligence (Work hard)
Discretion (Respect confidence and privacy)
Self-improvement (Be the best that you can be)
Nonmaleficence (Don't hurt anyone)
Restitution (Make amends to persons injured)
Self-interest (Protect yourself)

* From White, W., & Popovitz, R. (2001). *Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*. Bloomington, IL: Chestnut Health Systems. Used with permission.

What professional duties and obligations do you have as an addictions counselor during non-working hours?

As an addictions counselor, you have rights to privacy—areas of your life that are not open to professional scrutiny or accountability, but you also have duties and obligations that transcend an 8-hour work shift. The question then is where and how one draws this line between your rights to privacy and your professional duties and obligations. The concept of "nexus" has been used to define this boundary. The principle upon which it is based is that what you as an addictions counselor do in your own private life is exactly that—PRIVATE—until such time as there is an inextricable nexus—linkage or connection—between that private behavior and your professional performance. What you implicitly pledge when you enter this field is to not do anything in your personal life that destroys your ability to function as an addictions counselor. You must, for example, avoid private conduct (e.g., illegal or immoral behavior) that threatens your reputation and the reputation of your employing agency (e.g., making clients/families less comfortable seeking services with you or the agency). This principle also calls upon you to notify your supervisors when any issue in your private life threatens to compromise your professional performance (e.g., the existence of pre-existing relationships or other conflicts of interests with persons seeking service).

What ethical issues arise related to the professional conduct of the addictions counselor (outside the arena of relationships with clients)?

There are a wide variety of ethical and professional practice issues for addictions counselors that occur outside the context of relationships with clients and families. Some of the more troublesome issues you could encounter include:

- misrepresenting your education, training or experience via self-report, resumé or failing to correct others who mistakenly inflate your credentials,
- practicing beyond the boundaries of your education, training and experience,
- misusing agency resources,
- conflicts over ownership of work products, and
- conflicts of interest involving secondary employment.

NAADAC Principle 5 explicitly calls upon you to respect the limits of present knowledge and to "state as facts only those matters which have been empirically validated as fact." This is not to say that you can never express your opinion, but that you must be very clear in your separation of fact and opinion in communications to clients/families, to professional colleagues and to the public and express what those opinions are based upon.

What are some of the most critical ethical issues that will arise in your relationships with clients and families?

There are virtually hundreds of ethical and boundary issues that can arise within your relationships with clients and their families. While there is a tendency to define appropriate responses to many of these issues in very prescriptive terms, subtler and sometimes dramatic changes occur in what is ethically appropriate as we move across the boundaries of cultures, different client populations, and even across different developmental stages of the same counselor-client relationship.

What follows is a discussion of some of the most troublesome areas within the ethical territory of the counselor-client relationship.

A. Definition of Client Helping professionals are bound by all kinds of regulations and standards defining what they should and should not do in their relationships with clients, but many of these regulations and standards fail to define client. When does a person's status as a client begin and end? Does a client always remain a client? Does the term "client" include family members of those being counseled? Do addiction counselors working in non-clinical positions (e.g., prevention, training, research, supervision) have clients?

There are several trends relating to the definition of client. One is the position of "once a client, always a client." This stance, which takes the position that you as a counselor never lose the power to potentially exploit the counseling relationship, is reflected in NAADAC's Principle 9d: "The NAADAC member shall not under any circumstances engage in sexual behavior with current or *former* clients" (emphasis added). This position may be particularly apt for the addiction counselor given the chronic, relapsing nature of addiction. The ethical codes of some other helping professions and some criminal statutes prohibit sexual contact before a prescribed period (usually two years) following service termination. A growing number of these codes are also explicitly including family members in the definition of client. As for the application of ethical codes to non-clinical staff, a growing number of agencies are developing codes of professional practice that apply to all board members, staff, consultants and volunteers, and some professional organizations are developing standards that apply specifically to those in specialty roles, e.g., prevention (e.g., the IC&RC Code of Prevention Ethics).

B. Informed Consent The goal of the informed consent process is to assure that all persons considering entry into treatment are fully informed of the exact nature of the treatment

and, having been appraised of all potential benefits and potential risks of treatment, are free to participate or refuse to participate. The ethical prerequisites of informed consent are that the client is competent to provide informed consent (e.g., developmental maturity, absence of cognitive impairment), is free from coercion in providing informed consent, has been given objective information related to the potential risks and benefits of treatment and treatment alternatives, and is informed that he or she is free to revoke informed consent and withdraw from treatment at any time (McCrady & Bux, 1999).

C. Confidentiality Special procedures (federal and state statutes) have been developed to assure the confidential nature of addiction counseling. The ethics textbooks and major journals in the addictions field have paid special attention to the issue of confidentiality, and this issue is also addressed in chapter 24 of this book. It is the responsibility of every addictions counselor to clearly inform every client of the scope and exceptions to confidentiality and to rigorously adhere to these boundaries. There are quite subtle areas in which confidentiality can be commonly violated. (Edit Note: Coordinate revisions based on what is covered in Chapter 24)

1. Internal Confidentiality Disclose information inside the agency only to those in a "need to know" situation and disclose only role-appropriate information. Communications beyond these boundaries constitutes professional gossip and violates the ethical principles of privacy and discretion. NAADAC principle 8d calls upon the addictions counselor to "discuss the information obtained in clinical, consulting or observational relationships only in the appropriate settings for professional purposes that are in the client's best interest."

2. Casual Inter-agency Encounters There are a growing number of multiple-problem clients and families who bring extensive service histories with many community agencies. Shared experience with these clients and families breeds an informality of communication across agency boundaries that can lead to non-malicious breeches in confidentiality. Avoiding such breeches requires discipline and rigorous self-monitoring.

3. Casual Encounters with Clients in Public Another potential area in which confidentiality can be violated is during encounters with clients outside of the professional setting. For counselors residing in smaller communities, such encounters are common. Problems resulting from these encounters can be minimized by talking about the possibility of such encounters with each client and working out a mutually agreeable etiquette for such situations.

D. Dual Relationships Dual relationships occur when you agree to counsel someone with whom you have another relationship or connection that could compromise your objectivity or the client's comfort. Most professional associations and certification/licensure bodies prohibit or strongly discourage entering into counseling relationships with persons with whom one has a pre-existing, non-clinical relationship or connection. NAADAC, for example, prohibits its members from entering into counseling relationships with family members, current or former intimate partners, friends, close associates and "others whose welfare might be jeopardized by such a dual relationship."

The fact is that dual relationships will be inevitable for many addiction counselors, particularly those working in isolated rural communities or whose practice focuses on members of a "small town" within a larger community, e.g., a gay therapist working primarily with gay, lesbian, bisexual and transgender clients. Prohibiting all dual relationships would be impractical under those circumstances and would deny many people access to services. Such relationships must be individually evaluated based on their degree of intimacy and the extent to which the nature of the relationship would compromise your effectiveness and the client's psychological safety and comfort.

1. Pre-existing relationships A good working principle is that you should declare any pre-existing relationship with a client to your supervisor and use the supervision process to determine whether this client should be transferred to another counselor or another agency. Where such

transfer is not possible, e.g., where no other service alternatives exist, it is possible that counseling will need to be done in spite of such dual relationships. In this case other protections must be used to minimize the potential harm, e.g., informed consent (including a discussion of the pre-existing relationship and its potential effect on counseling), increased supervision, and more meticulous documentation of the counseling process.

2. Social/business relationships Addiction counselors are discouraged from working with people with whom they have social or business relationships and to not initiate such relationships with clients. Such relationships compromise the counseling relationship by shifting the fiduciary relationship (decisions made in the best interest of the client) to a reciprocal relationship (decisions made to meet the mutual interests of both parties). Such dual relationships inevitably spill clinical material into the social relationship and social interactions into the clinical relationship, leaving both counselor and client confused as to which roles they are occupying at any point in time. Such confusion usually produces poor friendship and poor counseling.

3. Recovery peer relationships One of the most frequent dual relationship questions that arises in the field of addiction counseling is the question of contacts between a recovering counselor and his or her clients in outside-of-work recovery activities. The most common questions include: How should I handle social contact with clients at recovery meetings? How should I respond when current or former clients ask for a ride to a meeting or ask me to sponsor them? How should I handle my own disclosures at meetings in which current or former clients are present?

The folk wisdom that has grown up over the years is designed to protect the integrity of the counseling relationship and the sobriety of the counselor. Such folk wisdom has been canonized within the *A.A. Guidelines for A.A. Members Employed in the Alcoholism Field*. These guidelines emphasize the importance of separating one's role as an A.A. member from one's role as an addictions counselor. To do this, A.A. members are encouraged to avoid using professional jargon in their A.A. role, speaking for A.A. in their professional role, and sponsoring people with whom they have a professional relationship. (The ICRC code of ethics specifically prohibits sponsorship of current or former clients or their family members.) They are encouraged to clarify with clients and their fellow professionals when they are speaking as a counselor and when they are speaking as an A.A. member.

Individuals whose personal recoveries have been aided by their affiliation with A.A., N.A. or other recovery mutual aid groups bring assets that can contribute to their effectiveness as counselors, but such affiliations can also create areas of blindness and bias. It is essential that the recovering counselor not push all clients into his or her own pathway or style of recovery. This requires developing knowledge, tolerance and respect for alternative frameworks of recovery.

4. Sexual Relationships A sexual relationship between a counselor and a client can emerge from a confluence of conditions: unmet needs in the counselor's personal life, the counselor's manipulation of the work environment to meet these needs, weak or non-existent clinical supervision, and "closed, incestuous organizations" that poorly define boundaries between staff and clients (White, 1995, 1997). Sexual intimacies between a counselor and client are best viewed as processes rather than events--acts that are the last stages of a progressive violation of intimacy barriers within the service relationship. This understanding provides an opportunity for self-monitoring of early drift within the counseling relationship (see Sidebar).

Warning Signs of Boundary Drift (Over-involvement)
Preoccupation with/possessiveness of client
Resistance to referral when clinically indicated
Increased frequency/duration of sessions
Sexualization of session content
Excessive self-disclosure
Escalation of touch
Evidence of client dependency
Resistance to supervision
Contact outside the professional setting
Courtship behaviors (e.g., increased phone contact, dressing up for appointments, personal gifts)

E. Self-Disclosure There is an extensive body of professional literature on the question of whether and when counselor self-disclosure is an effective clinical technique. The question we will address here is under what conditions your self-disclosures could actually do harm to the client, to yourself or your organization. Such harm can occur when your self-disclosure breaks the fiduciary promise by shifting the focus of the counseling session to yourself, or when the nature of your disclosure (by its nature or timing) injures the service relationship. In general, self-disclosure should be used sparingly, selectively, and strategically. When used, self-disclosures should be brief, appropriate to the developmental stage of the client and the client-counselor relationship, end with an opening for the client to link the disclosure to their own experience, and involve only material over which the counselor has achieved distance and emotional control. In terms of potential threat to you and your agency, you should also understand that confidentiality is not reciprocal. Clients are under no obligation to hold secret what you share with them, and the re-disclosure (and frequent misinterpretation) of this information could result in unanticipated harm to your reputation and the reputation of your agency.

F. Disengagement While problems of over-involvement between the addictions counselor and his or her clients have garnered much attention in the ethics literature, little attention has been paid to the ethical issues inherent in a counselor's under-involvement in such relationships. Significant harm can occur from the failure to engage a client or from the premature disengagement of the counselor from the helping relationship (clinical abandonment). Such acts can result many conditions, e.g., personal depletion or impairment of the counselor, excessive caseloads, or negative counter-transference in the counselor-client relationship. Warning signs of disengagement are illustrated in the accompanying table.

Warnings Signs of Disengagement
Lack of preparation for interviews
Drift of counselor attention during interviews
Aversion to seeing particular clients
Failure or delays in returning client phone calls
Decreased frequency/length of sessions
Unfocused, superficial content of sessions
Disrespect of clients
Adversarial relationships with clients
Depersonalization of clients (e.g., use of labels)
Precipitous, unprocessed terminations

G. Experimental Techniques New techniques that are lauded for their clinical effectiveness but which lack empirical support raise two issue for the addictions counselor: 1) practicing within the boundaries of competence in the mastery of such techniques, and 2) the potential iatrogenic (harmful) effects of these techniques even when competently executed. Counselors should maintain a critical skepticism regarding fads in treatment/counseling; popularly reported breakthroughs in the treatment of addiction have been notoriously unreliable for more than 200 years.

NAADAC Principle 3a demands that the addictions counselor "recognize boundaries and limitations of the member's competencies and not offer services or use techniques outside of these professional competencies." Even where experimental procedures are delivered with a level of assured fidelity, procedures need to be taken to prevent potential harm to clients. These steps include the use of informed consent prior to implementation of the procedure, rigorous supervisory review, and reasonable efforts to assess the degree of effectiveness of the procedures and the presence of any harmful side effects of the intervention.

H. Documentation There are several ethical issues related to documentation that you may encounter over the course of a career as an addictions counselor. Some of the most common and more difficult of these include:

- failure to adequately document service activity.
- breaches of confidentiality related to inadequate security of documents (e.g., loss of an appointment book, briefcase or laptop containing client information).
- documentation of clinically irrelevant information that could do potential harm to the client, e.g., details of criminal activity.
- unethical and fraudulent service documentation/billing.

This list underscores the potential ethical problems inherent in under-documentation, over-documentation, and undue attention to the disposition of any information about clients whether that information is in the form of paper, electronic documents, audio/video-tapes or photographs. Special care must be taken to assure the security of clinical information stored and transmitted via computer.

What are the most common ethical issues that arise within the professional peer relationships of the addiction counselor?

Some of the most frequent ethical issues that arise within professional peer relationships include the following: responding to allegations of unethical conduct of a peer, impairment of a professional peer, intra-agency confidentiality, intra- and inter-agency conflict management, fee-splitting (accepting financial or other incentives for referrals), abuses of power in supervisory relationships, dual relationship conflicts involving supervisors and supervisees, and whistle-blowing.

NAADAC's ethical Principle 2d calls upon the addictions counselor to report allegations or observations of unethical conduct by other service professionals to appropriate authorities. It is NOT the counselor's responsibility to determine whether such an allegation is true or not true before reporting it.

The NAADAC code of ethics (Principle 10c) explicitly prohibits addiction counselors from emotionally, sexually or financially exploiting relationships of unequal power, e.g., with supervisees, student interns, research participants or volunteers. Addiction counselors have a responsibility to ethically manage sexual feelings toward those they supervise in the same way they would be expected to manage such feelings toward clients. The principles governing dual relationships with clients have director applicability to the supervisor-supervisee relationship. The ICRC Code of Ethics for Clinical Supervisors, for example, explicitly prohibits entering into

dual relationships in supervision, exploiting the supervision relationship, or transforming clinical supervision into psychotherapy. Regarding the latter, the Code states: "personal issues should be addressed in supervision only in terms of the impact of these issues on clients and professional functioning."

How should you respond when you encounter situations in which a client poses a threat to themselves or others?

Situations involving potential harm to self or others requires a clinical response (assessment or degree of risk and interventions to lower risks) and an ethical response (interventions to protect the interests of multiple parties). The latter often involves weighing the clients right to confidentiality versus the potential threat of imminent harm to other parties. Two terms are invoked in the literature of law and ethics regarding such situations. Duty to report is a phrase used to denote the counselor's responsibility to disclose to a responsible authority either self-reported or observed injury by a client to another party (e.g., the abuse of a child or an elder). Addiction counselors are defined as "mandatory reporters" in most states, which means that promises of confidentiality do not include client disclosure of or observation of abuse of the client's children or aging relative. In this case, the child or elder's right to be protected outweigh the client's right to confidentiality. To manage these co-existing loyalties to the client and other parties, it is important for each client to know when the rights of others take precedent over their own. This is managed through discussions of the exclusions to confidentiality with each client.

A second term, duty to warn, describes the addiction counselor's responsibility to intervene to thwart a threat of harm by the client to other individuals. Such interventions, like duty to report, pit the client's rights of confidentiality against the threatened parties' rights to be warned of the threats to their safety. This is an area in which legal and ethical interpretations of counselor responsibilities can differ dramatically. A literal interpretation of most confidentiality statutes would preclude the counselor's breaking confidentiality to disclose such a threat. Ethicists, however, often argue that the counselor has a responsibility to prevent harm to others and that this responsibility supercedes the right to confidentiality when two conditions are met: 1) there is a clear target of the threat (one or more persons have been named) and 2) the threat of harm to the individual is judged to be imminent.

What ethical issues arise in the performance of special roles within the addictions field?

Over your career, you may work in many different roles and different modalities of addiction treatment and in such specialty roles as prevention, early intervention (student assistance, employee assistance), training, or research. These specialty areas differ from arenas in which ethical responsibilities are more clearly defined. They may involve areas where elaborate structures of ethical compliance exist (such as in human research) or areas in which very little of the ethical territory has been charted (such as prevention). When you move into such specialty areas, you have a responsibility to prepare yourself for the ethical issues that can arise in this new professional territory. (Those addiction counselors who are also working in the prevention arena are strongly encouraged to review ICRC's Prevention Ethics Standards.) Mastering the ethical nuances within these specialty roles requires reading, seeking out training, interviewing peers experienced in the area, and actively pursuing supervision and consultation.

What steps can help the addiction counselor elevate his or her level of ethical practice and what strategies can be used to proactively manage areas of potential ethical vulnerability?

If I were to offer some closing advice to the aspiring addiction counselor, it would include these key points.

- Take care of yourself! Effective self-care is an essential precursor to ethical conduct; it is the physically, emotionally and spiritually depleted counselor who is most vulnerable to using clients to meet these unmet needs.
- Get ethically educated! Ethical decision-making is as much about skill as it is about character. Seek out self-instructional reading and training that provides a safe environment for rehearsing and sharpening your basic ethical decision-making skills.
- Utilize Mentors! Develop a small cadre of consultants that can provide a sounding board and objective advice on difficult ethical dilemmas.
- Know thyself! Practice rigorous self-monitoring in order to identify when you are moving into periods of heightened personal vulnerability and when you are entering a zone of ethical vulnerability in your relationship with one or more clients,
- Ask for help! Seek formal consultation when you are in a zone of vulnerability and when there appears to be an exception to the normal ethical prescriptions.
- Protect yourself! There are times that it is clinically warranted to be in the zone of vulnerability we have described. Just don't be there alone, and create a paper trail (e.g., a journal) within zones of vulnerability that document your ethical decision-making processes and decisions.
- Finally, respect your clients, your co-workers, your craft and yourself by adhering to the ultimate ethical mandate, "First, do no harm!"

Acknowledgement: I would like to acknowledge Michael Wagner, one of the leading ethics trainers in the addictions field, for his helpful review of an early draft of this chapter.

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Glossary

Boundary: demarcation of the level of intimacy in the counselor-client relationship.

Code of Professional Practice: an organizational code of standards that defines aspirational values, ethical mandates (Thou shall or shall not...), folk wisdom (It has been our experience that...), procedural directives, and organizational etiquette.

Conscientious refusal: refusal to comply with a directive to commit an unethical or illegal act.

Dual Relationship: simultaneous or sequential involvement in two or more roles between a counselor and a client, e.g., counselor-client relationship, counselor and client are also next door neighbors, and client-neighbor is also the teacher of the counselor's child.

Duty to Report: the ethical obligation to report harm to others that has already occurred, e.g., reporting the abuse of a child.

Duty to Warn: the ethical responsibility to report the threat of harm to another person.

Ethics/Ethical: a body of values, principles and standards developed by a profession to guide its member's fiduciary service relationships.

Ethical dilemma: a situation in which the ethical course is unclear and which different course of action could be ethically justified.

Fiduciary: the assumption of professional responsibility for the care of another

Iatrogenic effect: interventions that produce inadvertent harm or injury to a client, family or community.

Informed Consent: the process through which potential clients are educated about the risk and benefits of addiction counseling prior to their decision to participate or not participate in such counseling.

Nexus: the linkage between private behavior and professional role performance.

Whistle-blowing: a counselor's disclosure of unethical or illegal activity within their organization to an outside investigative body.

Zone of Abuse: a zone in which the service relationship (either from too little or too much intimacy) has the potential of doing great harm to the client, the counselor and the agency.

Zone of Safety: a zone of routine service delivery in which a high degree of physical and psychological safety exists for the client and the counselor.

Zone of Vulnerability: a zone of heightened or diminished intimacy in the client-counselor relationship in which the vulnerability of both parties has increased.



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Citation: White, W. (2004) Transformational change and addiction recovery. *Counselor*, 5(4), 30-32. Posted at **www.williamwhitepapers.com**

Transformational Change and Addiction Recovery

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For the past several years, addiction counselors across the country have been indoctrinated with the idea that addiction recovery is a time-sustained process marked by multiple stages of change. Presentations on the Prochaska, Norcross, and DiClemente (1994) stages of change model and other developmental schema of recovery (e.g., Brown, 1985; Gorski, 1989; Klingemann, 1991) regularly grace the menus of addiction treatment conferences. These models portray the journey from addiction through recovery initiation to recovery maintenance in terms of incremental stages and steps spanning months and years.

While these models have great clinical utility for the majority of clients of the addiction counselor, they obscure a less common style of addiction recovery that is not characterized by such time-dependent processes. These latter recoveries are the fruit of dramatic personal transformations of such overwhelming intensity and depth that, in the span of moments or hours, a life is cleaved into the categories of before and after, leaving a new self in a body once occupied by another. In this article, we will explore historical examples of such climactic recovery experiences and explore the clinical implications of such phenomena.

Transformational Change

Transformational change (TC) is an alteration in personal identity, personal values and interpersonal relationships through an experience of change that is unplanned, profound, positive and permanent (Miller and C'de Baca, 2001). Scholarly studies of TC have long noted the potential of such experiences to initiate recovery from addiction and the resolution of other seemingly intractable problems (Starbuck, 1901; James, 1902; Begbie, 1909; Loder, 1989). These experiences range in type from the secular to the spiritual to the religious (Oates, 1978), but they share many qualities illustrated in the lives of individuals who used their TC experience as a foundation to launch abstinence-based healing and religious/cultural revitalization movements.

Transformational Change and History

Handsome Lake lived a drunken, debauched life in the years preceding his

apparent death in 1798. During preparations for his funeral, Handsome Lake awoke to report that he had died but that the Great Spirit had restored his life so that he could deliver a message to Indian Peoples. The forever sobered and transformed Handsome Lake led a vibrant cultural and religious revitalization movement that called upon Native Americans to reject alcohol and return to their ancestral traditions (Parker, 1913).

John Gough was a confirmed drunkard and brawler (once tried for murder). His life changed when a stranger stopped him on the street and offered to help him recover from his drunkenness and degradation. Something within Gough emotionally broke in response to the stranger's expressions of kindness and confidence in him. His hardened shell collapsed and new possibilities opened before him. He signed a pledge of abstinence and went on to become one of the leaders of the Washingtonian Temperance Society. His charismatic speeches and personal counsel brought thousands of alcoholics into recovery in the mid-nineteenth century (Gough, 1870).

Jerry McAuley, an alcoholic and lifelong criminal, was in Sing Sing Prison for highway robbery when he experienced the first of a series of climactic breakthroughs that let to his conversion to Christianity, his recovery from alcoholism, and his calling to help other alcoholics. McAuley opened the Water Street Mission in New York City, the first urban mission that catered to the special needs of the Skid Row alcoholic (Offord, 1885).

Bill Wilson did not have a good prognosis for recovery when he was re-hospitalized for alcohol detoxification for the fourth time in the fall of 1934. In a moment of desperation, Wilson, a staunch non-believer, cried out within his hospital room, "If there is a God, let Him show Himself!" The room suddenly became ablaze with light, and Wilson was overwhelmed by a Presence and the singular thought that he was now a free man. Wilson never took another drink in his life and went on to co-found a fellowship that brought recovery to millions of alcoholics (Alcoholics Anonymous, 1984).

Mrs. Marty Mann, the first woman to achieve prolonged sobriety within AA, also had a TC experience that helped trigger her recovery. Following this climactic experience, she founded the National Council for Education on Alcoholism and went on to become one of the most successful public health reformers in American history (Brown & Brown, 2001).

Malcolm Little a.k.a. "Detroit Red" was an incarcerated, cocaine-addicted street hustler whose animosity toward religion was so vociferous that he was nicknamed "Satin" by his fellow inmates. Following exposure to the teachings of the Nation of Islam through his siblings, he experienced a vision in his jail cell of W.D. Fard, the deceased messiah of the Nation of Islam. Following his conversion and new identity, Malcolm X forged a cultural/religious pathway of addiction recovery for African Americans and sparked the dramatic growth of the Nation of Islam during the 1950s and 1960s (Malcom X and Haley, 1964).

What these remarkable stories share in common are recovery-initiating experiences that were unplanned, dramatic and permanent in their effects. Nearly all of the experiences unfolded during a period of isolation and emotional desperation. The source of the transformational change in each case was experienced as coming from outside the self. Each was characterized by physical manifestations, including vivid, non-ordinary sensory experience (e.g. visions, voices, trance-like states) that left the recipients questioning their sanity. The experiences were more analogous to a seizure than an insight or decision. Each experience culminated in a deep emotional release, new and profound breakthroughs of understanding, a new sense of purpose in life, and prolonged sobriety. Seen as a whole, these cases were marked by 1) a period of isolation and traumatic discontent, 2) exposure to a message/messenger of hope, 3) a breakthrough experience of remarkable intensity, 4) external validation of the experience, and 5) entrance into a

community of shared experience (White, in press).

Lesson of History

What are we to make of these stories and their less well-known counterparts. These stories suggest at least five lessons.

1. Transformational change is a viable, but poorly understood pathway of addiction recovery. We must be open to the potential for such transformations in the lives of those we serve.

2. TC experiences often contain elements that closely resemble, and may be misperceived as, symptoms of psychiatric illness. We must be patient in allowing sufficient time and support to distinguish clinical deterioration from personal metamorphosis.

3. Transformational change is characterized by two overlapping experiences, a breakdown and a breakthrough. What many of the above-profiled individuals retrospectively understood was that their addictions were imbedded within irredeemable selves that had to die before their new selves could be born. Recovery is both destructive (the collapse of an indelibly stained self) and creative (the emergence of a new self). This metamorphosis can occur over decades or a span of moments.

4. The TC experience has a momentum and trajectory that should not be altered or aborted by professional intervention. William James advises, "When the new centre of personal energy has been subconsciously incubated so long as to be just ready to open into flower, 'hands off' is the only word for us, it must burst forth unaided!" (1902/1985, p. 187).

5. The addiction counselor can help nurture and consolidate experiences of transformational change by:
   - heightening client awareness of the incongruity between the idealized and real self,
   - creating opportunities for client isolation and self-reflection,
   - being with a client during the TC experience and assuaging anxieties and fears related to the experience,
   - helping frame the TC experience within a recovery-anchoring personal narrative,
   - facilitating the transition from the TC experience to a sobriety-based identity and lifestyle, and
   - linking the client to a community of shared experience or encouraging the client to build such a community.

The messianic vision and evangelical zeal that are a common aftermath of the transformational change experience have spawned many recovery mutual aid and recovery advocacy movements. Addiction counselors never know when they may be called by history to play the role of midwife in the birth of such movements.

A Closing Reflection

Perhaps there is a broader lesson in all of this. That lesson is that there are brief developmental windows in all of our lives that provide opportunities to change who we are at a most fundamental level. The TC experience serves as a catalyst for addiction recovery, not by removing alcohol and drugs from an otherwise unchanged person, but by birthing a new self in which alcohol and other drugs have no role. We would be well advised to respect the potential for such mysterious, positive processes of change—in our clients and in ourselves.

Acknowledgement: I would like to thank William Miller whose invitation to write an article on this subject for a special issue of

IN SESSION: Journal of Clinical Psychology provided the opportunity for the historical research upon which this essay is based.

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Citation: White, W., Boyle, M. & Loveland, D. (2004) Recovery from addiction and recovery from mental illness: Shared and contrasting lessons. In Ruth Ralph and Pat Corrigan, Eds. Recovery and Mental Illness: Consumer Visions and Research Paradigms. Washington DC: American Psychological Association, pp 233-258. Posted at **www.williamwhitepapers.com**

Recovery from Addiction and Recovery from Mental Illness: Shared and Contrasting Lessons

William White, MA, Michael Boyle, MA, and David Loveland, PhD.

A qualitative shift is occurring in the conceptual foundation and design of behavioral health services. Grassroots advocacy movements and a growing body of longitudinal research are challenging mental health and addiction treatment service providers to re-focus their services toward the goal and processes of long-term recovery. In the mental health field, the "ex-patients' survivor" movement of the 1970s (Chamberlin, 1978) was followed by new "consumer" voices in the 1980s (Deegan, 1988; Unzicker, 1989) and the christening of the 1990s as the "decade of recovery" (Anthony, 1993). Dramatic changes in the conceptual underpinnings of mental health treatment were spurred by research studies confirming that between half and two-thirds of people with serious mental illness achieve substantial recovery (Harding, 1989; Harding, Brooks, Ashikaga, Strauss & Breier, 1987; Harding, Zubin, & Strauss, 1992; Strauss, Gagne, & Koehler, 1985). Today, well-organized ex-patient/consumer/survivor groups and visionary professionals are moving beyond the call for "recovery-oriented" systems of care to actually creating such systems (Anthony, 2000).

The addiction treatment field is being similarly challenged by a "New Recovery Advocacy Movement" led by recovering people and their families (White, 2000b; 2001b). These recovery advocates and their professional allies are demanding that addiction treatment be reconnected to the larger and more enduring process of recovery, and that treatment shift from serial episodes of unconnected acute interventions to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, in press).

The consumer and professional renewal movements within the mental health and addiction treatment fields have much that they can learn from one another. Both movements are trying to shift from a focus on symptom suppression to global health and development. Both are trying to balance the preoccupation with managing social costs with more qualitative measures of service outcomes, e.g., post-treatment meaningfulness and quality of life. And yet, each field brings areas of marked contrast. Such similarities and differences suggest the potential for positive synergy between the two fields. In this article, the authors will

explore lessons from the addictions field regarding the recovery experience, recovery mutual aid groups, and recovery advocacy movements. Our focus will be on those lessons that may have relevance to personal recovery and political advocacy movements organized by and on behalf of people who have experienced psychiatric disability.

The Recovery Experience

A common theme noted throughout this book, and a theme that is central to the consumer/ex-patient/survivor movement, is that recovery from mental illness must be defined as a complex, dynamic, and enduring process rather than a biological end-state described by an absence of symptoms. Recovery is, in its essence, a lived experience of moving through and beyond the limitations of one's disorder. Viewing recovery in terms of an ongoing and highly personalized experience, rather than a biomedical disease, is a new and radical concept in the mental health field and one that requires a paradigm shift in how we think, how we design service systems, and how we conduct clinical research. In reviewing what has been learned about recovery in the addictions and mental health fields, we find the following findings most suggestive.

Recovery is the process of healing the effects of a) one's illness and its consequences, b) the social stigma attached to the illness, and c) the iatrogenic effects of treatment interventions (Spaniol, Gagne & Koehler, 2002). Recovery implies a process of retrieval (regaining what was lost due to one's illness and its treatment) and a process of discovery (moving beyond the illness and its limitations).

Treatment and recovery are not the same. Treatment encompasses the way professionals intervene to stabilize or alter the course of an illness; recovery is the personal experience of the individual as he or she moves out of illness into health and wholeness. Recovery is the experiential shift from despair to hope, alienation to purpose, isolation to relationship, withdrawal to involvement, and from passive adjustment to active coping (Ridgway, 2001). Recovery can occur within or outside the context of professionally directed treatment, and where professional treatment is involved, it may, depending on its orientation and methods, play a facilitative, insignificant, or inhibiting role in the recovery process. Recovery can be claimed only by the person in recovery, and that ownership includes the right to take risks, make mistakes and learn from one's experiences (Deegan, 1992).

Recovery exists on a continuum of improved health and functioning. The mental health field has long affirmed the concept of partial recovery (some residual disability with reduced social costs and improved health and functioning) but, until recently, has lacked a vision of full recovery from severe mental illness (minimal residual disability and resumption of pre-illness levels of health and functioning). In contrast, the addiction treatment field has had an unequivocal goal of full recovery (sustained abstinence and increased emotional and relational health) but has lacked an operational concept of partial recovery (reduced frequency and intensity of alcohol and other drug use and related problems and increased quality of life). It may be time for both fields to recognize within the growing genre of recovery narratives the existence of what might be called <u>transcendent recovery</u> (minimal residual disability and the achievement of health, functioning and quality of life superior to that which existed before the onset of illness). The concept of transcendent recovery acknowledges the existence of people who, following the experience of addiction and/or mental illness, get "better than well," not in spite of the illness but because of the experiences and insight that emerged within their recovery processes (Young & Ensing, 1999). It is within this experience of transcendent recovery that some people reframe their illness from a curse to a condition that brought unexpected gifts to their life.

The potential for recovery and the quality of recovery are determined by the synergy between recovery debits (personal and environmental factors that inhibit and

limit recovery) and recovery capital (internal and external resources that serve to initiate, sustain and expand recovery) (Granfield & Cloud, 1999). In what is likely to be a milestone study, Onken and colleagues (2002) explore the interaction of recovery facilitating and inhibiting factors drawn from the experiences of individuals in recovery from mental illness. They conclude that such factors exist at multiple, interacting levels: characteristics of the individual (e.g., the presence or lack of hope, resourcefulness, self-reliance, recovery self-management skills); characteristics of the environment (e.g., the presence or lack of safety-enhancing material resources--housing, transportation, healthcare, and a means of communication); and characteristics of the interaction between the individual and the environment (e.g., the presence or lack of meaningful relationships and activities, choices, empowering service and peer relationships). *There are many pathways to and varieties of recovery experience* (Humphreys, Moos & Finney, 1995; Vaillant, 1983). The course and outcome of alcohol and other drug problems vary across transient and persistent patterns. The former are amenable to self-resolution or brief professional intervention, while the latter often require sustained professional- and peer-based supports (Kandel & Raveis, 1989). Those with a more prolonged course often differ in the presence of greater personal vulnerability (e.g., family history, lower age of onset), greater problem severity, interlocked co-occurring problems, and low family and social supports. Recovery styles span natural recovery (without the aid of professional or peer support), peer-assisted recovery (mutual aid involvement) and professionally-assisted recovery (professional treatment). While there is a growing body of research on natural recovery from addiction (Granfield & Cloud, 1999), the absence of comparable data in the mental health field raises two important questions: 1) What is the prevalence of natural recovery among people with different types of mental illness? 2) How do those who experience natural recovery differ from those most frequently treated by mental health agencies?

There are variations in recovery style based on the extent to which one's disorder becomes a central part of one's identity, and one's degree of affiliation with a larger community of recovering people. There are acultural styles of recovery (no affiliation with other recovering people), bicultural styles of recovery (affiliation with recovering people and people without addiction/recovery backgrounds), and culturally enmeshed styles of recovery (emersion in a culture of recovery) (White, 1996). People in recovery display highly variable but viable styles of relationship to professionally-directed treatment, peer-driven support services and mutual aid societies. The addictions field is slowly (and painfully) learning to work within this variability of styles rather than attempting to program all recovery experiences through narrow vision of how recovery must be achieved and sustained. A cartography of pathways and styles of recovery from mental illness has yet to be drawn.

The role of self is essential to understanding the recovery process; the self, not the service professional, is the "agent of recovery" (Davidson & Strauss, 1992; Spaniol, Gagne, & Koehler, 2002). Recovering people are more than passive recipients of recovery. While they may draw on the clinical technologies of professional helpers and the "experience, strength and hope" of others in recovery, each recovering person must ultimately become the architect and engineer of his or her own recovery. Recovery involves a reconstruction of personal identity, a reformulation of the relationship between self and illness, and a reconstruction of one's relationship with the world. These dimensions are often evident in the three-part story style of people in recovery: 1) the way it was (depiction of the onset and course of the illness), 2) what happened (the experience of recovery initiation), and 3) what it is like now (depiction of life in recovery).

The initiation of recovery may be marked by processes of transformational or incremental change. The former, which has been christened "quantum change," involves

sudden, recovery-inducing experiences that are dramatic, unplanned, positive and enduring (Miller & C' de Baca, 2001). While quantum change has long been noted within the history of addiction recovery (White, 1998), the authors are aware of no studies exploring the role of quantum change experiences in initiating recovery from severe mental illness. In contrast, there are several studies that have explored the developmental stages of long-term recovery from addiction (Brown, 1985; Prochaska, DiClimente, & Norcross, 1992) and from mental illness (Davidson & Strauss, 1992; Jacobson, 2001; Morse, 1997; Ridgeway, 2001; Strauss & Carpenter, 1981; Weaver-Randall, 2002; Young & Ensing, 1999). These stage models of recovery depict a process of recovery initiation (acceptance of one's illness, hope and resolution for change, first steps toward self-management), a process of stabilization (ownership and active management of one's own recovery), a mastery of rituals of daily living (increased comfort and confidence, self-monitoring and active efforts to prevent relapse, deepened insight about self in relationship to illness) and a sustained movement toward health and a wholeness (increased quality of life via greater independence, self-acceptance, a safe and pleasant living environment, satisfying relationships, and meaningful activities). Several points are noteworthy about these models. First, those factors required to initiate recovery are often quite different than the factors that later serve to maintain and enrich recovery (Humphreys, Moos & Finney, 1995). This suggests that interventions helpful at one stage of recovery may be ineffective or even harmful at other stages. For example, continuing to provide "care taker" functions within an assertive community treatment model could well have iatrogenic effects upon individuals who are developmentally ready to take ownership of their own recovery. The extent to which these developmental stages of recovery differ by type, severity and duration of illness and across developmental age, gender, and culture is an important research agenda.

There are critical points (developmental opportunities) that arise within the prolonged course of a disorder that constitute doorways of entry into recovery or opportunities to move from one stage of recovery to another (Young & Ensing, 1999). These milestones can mark a shift either toward greater problem severity or the initiation or qualitative strengthening of recovery. When such transitional experiences initiate or deepen recovery, they are nearly always characterized by a synergy of pain and hope. This birth of hope that is such a central theme in recovery narratives almost always occurs in the context of relationships and resources beyond the self, and often occurs through encounters with the "experience, strength and hope" of others in recovery. Historically, the addiction field believed that recovery initiation was grounded in the experience of pain ("hitting bottom"), but there is growing recognition that the deepest despair incites recovery only in the presence of hope. It is often at the point of this synergy of pain and hope that people suffering from addiction and/or mental illness, like the mythical Phoenix, rise from the ashes of their own self-destruction (Johnson, 1993; White, 1996).

Recovery occurs at a different pace across a number of zones: physical, intellectual, emotional, relational, personal (rituals of daily living), and spiritual. Progress in one zone can help prime and sustain positive change in other zones.

Spirituality is a potentially important but often ill-understood ingredient of the recovery process (Sullivan, 1994). The role of spirituality to provide hope, to neutralize stigma and shame, and to bolster strength and courage are frequently noted in recovery narratives (White, 1996; Young & Ensing, 1999). The addictions field has a long history of emphasizing the role of spirituality in the recovery process -- so much so that purely secular frameworks of recovery are lauded as innovations. Mental health professionals are just beginning to explore the role of spirituality in recovery. What the addictions field is slowly learning is that, like many aspects of recovery, spirituality is a highly personal experience and a choice, not

something to be codified within a "program."

People recovering from two or more co-occurring problems may address these interacting processes simultaneously (dual recovery) or sequentially (serial recovery). People may be at different stages or levels of motivation for addressing various problems that they are experiencing. The same person can experience differential rates of recovery from multiple disorders/experiences, e.g., mental illness, addiction, traumatic victimization and loss.

The relationship between medication and recovery is a complex and potentially stage-dependent one. The addiction and mental health fields have histories that underscore the value as well as the potential iatrogenic effects of medications on the recovery process. The mental health field has had a bias towards medication, including medications with severe and debilitating side effects (e.g., Cohen, 1994; Cohen & McCubbin, 1990; Valenstien, 1998). The addictions field has had a bias against medication, even when those medications have had overwhelming research support for their safety and efficacy, e.g., methadone. The narratives of recovering people emphasize that medication can facilitate or hinder recovery and that symptom elimination or minimization via medication, in and of itself, does not constitute recovery. The future promises more effective medications and a widening menu of alternatives and adjuncts to medication.

*Both illness and recovery require substantial adaptational energy of one's family and social network*_(Brown, 1994; Brown & Lewis, 1999). The responses of family members to illness and disability and to stages of recovery represent normal rather than pathological reactions. Family recovery is the process of finding the best ways to adapt to the presence and then the absence of illness as an organizing motif within the family system. There may be developmental stages of family recovery that parallel the stages of personal recovery. It has been suggested that family members make these adaptations in their own style and at their own pace (Spaniol & Zipple, 1994). There is a marked absence of research on how family members of persons with severe mental illness and the family as a whole recovers from the impact of mental illness and its associated stigma. In the addictions field, interest in this area evolved from the concept of co-alcoholism, into offering "family programs", to the emergence, corruption (by over-extension) and commercialization of the concept of co-dependence. The latter stage created an ideological backlash that has diminished interest in this area by clinicians and researchers.

Recovery involves transcending the stigma that has been attached to addiction and/or mental illness. Stigma within the larger culture creates conceptual (how one sees oneself) and concrete (discrimination resulting from how one is seen by others) barriers to recovery. Stigma-shaped practices within treatment systems have also served to depersonalize and dehumanize. Deegan (1990) has collectively christened such practices as "spirit-breaking." Confronting and exorcising stigma within oneself (self-healing) and within one's environment (political advocacy) are frequent dimensions of the recovery process.

Language is important to personal recovery (Spaniol & Cattaneo, 1997; White, 2001). Words are the conceptual building blocks of recovery. The ability of recovering people to coin or select words that accurately and respectfully portray their experiences and aspirations is a crucial dimension of the personal recovery experience. Words have long been used to objectify and demonize people experiencing mental illness and substance use disorders. In recovery, alternative words become instruments of personal and collective liberation. Crafting language is about personal and social change, not political correctness.

Recovering people can become their own recovery experts (Deegan, 1992). Recovering people have also served within the "wounded healer" tradition for more than two centuries, with such service work providing a boon to others and a source of strength within their own recovery processes

(White, 2000a). A few important lessons from this tradition within the addictions field may be important for the rising "prosumer" movement in the mental health field.

- Paid service work is not a program of personal recovery and, for some individuals, can pose a significant obstacle to recovery.
- People in recovery can work as prosumers in circumstances that are empowering to their recoveries (e.g., treated with respect, held accountable, and provided salaries commensurate with their work) or work in circumstances that are disempowering (e.g., treated as "senior clients", hired as token consumers via minimal or lack of comparable performance expectations, exploited financially via low pay and excessive and undesirable hours, and abandoned and discarded in the face of relapse).
- People in recovery can become so "professionalized" that assets drawn from their own recovery experiences are lost.
- There is a danger that recruiting people from recovery networks into paid service jobs could undermine the service ethic within those networks. It is very important that distinctions be made between services for which one is paid and service work that is done as part of one's personal recovery process.
- While those who hold dual roles as "consumers" and service providers may serve as "translators" (interpreting and synthesizing the multiple voices within the mental health recovery advocacy movement) (Frese, 1998), the experiences of consumer-providers may not be representative of the larger community of recovering people, and the consumer-provider must avoid the problem of "double-agentry"—representing themselves as the voice of consumers while consciously or unconsciously representing their own financial interests and/or the institutional interests of service providers.
- People in recovery hired into service roles can benefit from special training and supervision on managing issues related to this duality of roles. (See expanded discussion below.)

Recovery Mutual Aid Groups: A Brief History

Peer-based systems of mutual support for addiction recovery predate the professionalized field of addiction treatment and their continued importance in long-term recovery support is a unique aspect of the addictions field. Such systems of mutual aid (reciprocal support as a solution to a shared problem) are distinguished from "self-help" approaches (efforts made by individuals to solve their own problems) (Ogborne, 1996). What addiction recovery mutual aid societies have provided is an esteem-salvaging framework for understanding illness, a cognitive and emotional roadmap of recovery, a strategy for reframing and countering stigma, and social support and fellowship. In this section, we will explore what the mental health field can learn from the addiction recovery mutual aid societies.

There is a long and rich history of addiction recovery mutual aid societies in America. Eighteenth century Native American recovery "circles" and other abstinence-based cultural and religious revitalization movements mark the beginning of peer-based models of alcoholism recovery. These were followed in the nineteenth century by mutual aid societies that emerged as part of the "rescue work" of the American temperance movement. The largest and most geographically dispersed of such societies included the Washingtonian Temperance

Societies (1840s), the fraternal temperance societies (1840s-1870s), and the ribbon reform clubs (1870s). There were also mutual aid societies that sprouted within inebriate asylums (Ollapod Club), inebriate homes (Godwin Association), the addiction cure institutes (Keeley Leagues), urban rescue missions (the United Order of Ex-Boozers; Drunkard's Club), and early twentieth century alcoholism clinics (Jacoby Club) (White, 2001a).

The founding of Alcoholics Anonymous (A.A.) in 1935 marks the beginning of modern addiction recovery mutual aid societies. A.A. has become the standard by which all mutual aid groups are measured because of its size (2.2 million members and more than 100,000 groups worldwide; 1.1 million members in the United States alone), its geographical dispersion (more than 175 countries) and its longevity (more than 65 years) (http://www.alcoholics-anonymous.org). As A.A. grew, its Twelve Step program was adapted for family members (Al-Anon-1951), for persons addicted to drugs other than alcohol (Narcotics Anonymous-1947-1953; Cocaine Anonymous-1982), and for persons suffering from addiction and other problems (Dual Disorders Anonymous-1982; Dual Recovery Anonymous-1989). There were also a growing number of religious adjuncts to A.A. (Alcoholics Victorious-1948; the Calix Society-1949; Jewish Alcoholics, Chemically Dependent People and Significant Others-1979) and alternatives to A.A. (Women for Sobriety-1975; Secular Organization for Sobriety-1985; Rational Recovery-1986; LifeRing Secular Recovery-1999; Teen-Anon, 1999, Moderation Management-1994) (White, in press). All of this offers testimony to the growing varieties of recovery experience within and outside of Alcoholics Anonymous.

Addiction recovery mutual aid societies constitute an important historical backdrop to modern mutual aid societies in the mental health field, e.g., Recovery, Inc.-1937; GROW, Inc.-1957; Emotions Anonymous-1971; National Alliance for the Mentally Ill (NAMI)-1979; Anxiety Disorders Association of America-1980; Schizophrenics Anonymous-1985; National Depressive and Manic-Depressive Association-1986; and Obsessive-Compulsive Foundation, Inc.-1986.[1] Because of the longer history, larger membership, and greater geographical dissemination of addiction recovery mutual aid groups, we thought that some of what has been learned in these groups might be helpful to existing and new recovery mutual aid groups in the mental health field. Seen as a whole, the addiction recovery mutual aid societies offer ten lessons about the promises and perils of peer-based models of recovery support (from White, 2001a, unless otherwise noted).

1. *Addiction recovery for historically disempowered peoples (groups that have suffered physical/cultural assault, enslavement, economic exploitation and oppression) must be offered within a framework of hope for a community as well as the individual and family.* Such frameworks have been particularly evident with Native American and African American communities who still suffer the effects of such oppression (e.g, African Americans represent 15% of illicit drug users, but more than 60% of drug-offenders entering prison; 1 in 20 African American men over age 18 is under the control of the criminal justice system, US Department of Justice, 2000; substance-involved African American women are 10 times more likely to be reported to child welfare agencies for prenatal drug exposure than their White counterparts, Neuspiel, 1996). In such communities, abstinence-based cultural and religious revitalization movements have long provided a shared pathway of addiction recovery and community survival and renewal (Coyhis & White, 2002; Williams & Laird, 1992). When Native American leaders proclaim that "the community is the

[1] The functions of mutual aid and advocacy are much more likely to be blended within the same organization within the mental health field.

treatment center," they point out the inextricable link between personal recovery and the broader health of the community in which that recovery is nested (*The Red Road to Wellbriety,* 2002). Such proclamations simultaneously provide hope to individuals and hope for the future of a people.

2. Recovery mutual aid societies are vulnerable to colonization by more powerful forces within their operating environments, particular domination by larger social or professional movements. A.A., for example, was deluged with groups wanting to join and use A.A. to address a wide variety of problems other than alcoholism. A.A. took the position that other groups could adapt the Twelve Steps and Traditions for their own use but could not become a member of A.A. unless they met A.A. membership criteria ("a desire to stop drinking"). The most resilient of the recovery mutual aid societies are ones that maintain their indigenous leadership and "closed" meeting structure. Successful recovery mutual aid societies must also carefully construct their relationship with professionally-directed treatment agencies. The historical relationship between mutual aid societies and treatment institutions is a complex one. Treatment institutions have emerged from mutual aid organizations, e.g., the nineteenth century Washingtonian Homes. Treatment institutions have co-opted and corrupted mutual aid organizations; e.g., the attempt to manipulate the Keeley Leagues to market the proprietary services of the Keeley Institutes. Treatment institutions have also created partnerships with mutual aid societies in which boundaries were clear and respected; e.g., the relationship between A.A. and local hospitals in the 1940s and 1950s. The long history of strain between mutual aid societies and professional treatment agencies has centered on: 1) poorly defined boundaries between mutual aid and professional treatment, particularly when people in recovery are hired to do the latter, 2) differences in philosophies and helping practices, and 3) the near universal attempt by professional agencies to colonize or at least control mutual aid movements. This tension has pervaded the history of mutual aid movements in the United States as well as the Alcoholic Treatment Clubs in Italy (Patussi, Tumino, & Poldrugo, 1996) and the Abstainer Clubs in Poland (Światkiewicz, 1992). Professionals have played important roles in the birth of many mutual aid societies, but have also played a role in conflict that has led to the demise of such groups.

3. Professionalism, money, property, publicity, and religious/political conflict are potential forces of dissension that can threaten the survival of local mutual aid societies. Money and professionalism are particularly problematic. Addiction mutual aid programs -- from the Washingtonians in the U.S. (White, 1998) to the Links Societies in Sweden (Kurube, 1992) -- have experienced strife when their members assumed paid helping roles. In Germany, for example, recovery activists condemn paid service work on the grounds that it creates status hierarchies within the recovery community (Appel, 1996). Guidelines governing how such dual roles can be maintained have helped manage these potential problems (*A.A. Guidelines*, ND). Maintaining ideological and financial autonomy seems to be crucial to the survival and health of mutual aid societies Outside funding has often turned out to be a mechanism of control and cooptation, and mutual aid groups have a long history of death via ideological (political and religious) schisms. Conflict over money, religion and politics within the early history of A.A. led A.A. to pledge itself to corporate poverty, self-sufficiency and neutrality on all outside issues. Based on A.A.'s example, American mutual aid societies have, until recently, tended to be financially self-supporting and neutral on questions of political or religious doctrine, whereas such societies in Europe are much more likely to be financially supported by the state (e.g., the abstainer clubs in Poland) and to be linked to particular political movements (e.g. the New Left influence on mutual aid groups in Germany) (Room, 1998). The recent growth of faith-based recovery ministries, church-based mutual aid recovery groups, and the funding

of these ministries by federal, state and local governments marks a new chapter in the history of mutual aid in America; these groups constitute a living experiment whose processes and fate warrant close examination.

4. The centerpiece of all successful recovery mutual aid groups is the process of sharing "experience, strength and hope." The glue of such societies is mutual identification and mentorship within relationships that are time-sustained, non-hierarchical, and non-commercialized. Recovery mutual aid groups constitute a community of shared vulnerability whose members draw resilience and power from the safety of this sanctuary to do things within their lives in consort that they could not do alone. These communities of recovery also constitute cultures of resilience and recovery (with their own language, values, rituals, and symbols) that for many constitutes alternative to the cultures of pathology and dependence within which they have been enmeshed. It is here that the most personal and intimate experiences of healing are wed to an intuitive understanding of the social ecology of recovery.

5. A major challenge of mutual aid societies is transcending the foibles and deaths of their founding, charismatic leaders. The Ribbon Reform Clubs that thrived across America in the 1870s and 1880s as local sobriety-based support fellowships collapsed as their charismatic leaders aged, suffered infirmities, and died. Successful mutual aid societies emphasize leadership development and rotation. For example, in A.A. groups, there are no elected officers and the meetings are chaired by a variety of members rather than by a single leader.

6. *The most resilient of the mutual aid societies utilize a highly decentralized cell structure; the essential organizational unit is the small, local group that provides its members a venue for mutual identification and support*. Such de-centralization allows forces of potential disruption (e.g., explosive growth, personality conflicts, ideological schisms) to serve as mechanisms of growth via the spawning of new groups rather than member attrition.

7. All addiction recovery mutual aid societies have had to decide how its members should respond to social stigma, e.g., from encouraging bold visibility (public declarations of one's addiction and recovery) to hiding one's stigmatized status via assurances of secrecy and anonymity. In cultures in which addiction or mental illness is highly stigmatized, mutual aid societies have provided a variety of vehicles through which its members could salvage their "spoiled identities." The Keeley Leagues of the 1890s defined recovery as sign of manhood, boldly challenged members to write letters to local newspapers proclaiming their recoveries, and proudly wore the Keeley League pin on their clothing. In contrast, other societies have promised their members confidentiality and discouraged or prohibited public disclosures of their affiliation. Where some societies integrate recovery and advocacy, others become secret societies. An interesting question is the extent to which such secrecy actually serves to perpetuate stigma. One is forced to wonder: What would the effect have been on public attitudes and public policies if hundreds of thousands of persons in recovery from addiction or mental illness had publicly proclaimed their recovery over the past decades? Strategies that protect members from stigma at an individual level may inadvertently help perpetuate that very stigma at a societal level. Some recovery advocates argue that living in silence and secrecy in terms of one's recovery status perpetuates stigma by withholding faces and voices of successful recovery and placing in the national consciousness images only of those who fail to recover.

8. Successful recovery mutual aid societies must have both a "program" or operational framework of recovery (e.g., A.A.'s Twelve Steps) and a set of core values (e.g., A.A.'s Twelve Traditions) to manage forces that can threaten the life of the organization. These forces include those earlier noted (ideology, professionalism, publicity, and money) as well as personality conflicts and sexual attraction or behavior

among members. Successful mutual aid societies develop values ("group conscience") and rituals to minimize interpersonal conflict (e.g., A.A.'s emphasis on "principles before personalities") and protect vulnerable members from potential exploitation by other members (e.g., the sexual exploitation of new members pejoratively referred to in A.A. as "Thirteenth Stepping").

9. The length of expected member involvement in a mutual aid society must reflect both the time span of needed recovery support of its members and what will be required to maintain the life of the organization. Lifelong mutual aid participation may not be a requirement for effective self-management of recovery, but a core of individuals committed to such participation may be crucial to the survival of any recovery mutual aid society.

10. Recovery mutual aid societies can peacefully co-exist, collectively offering a menu of pathways of recovery, or they can enter into competition and conflict in an effort to define the "right" pathway of recovery. The former is illustrated by the co-existence of many recovery support societies in Germany (Appel, 1996); the latter is illustrated by the acrimony that has sometimes characterized the relationship between members of A.A. and members of secular and religious alternatives to A.A. (White, 1998). Recovery pluralism is evident in the number of people who simultaneously participate in more than one mutual aid society or who move from one society to another during different stages of their recovery careers (Appel, 1996; Humphreys & Klaw, 2001).

While the above lessons are deeply imbedded within the history of addiction recovery mutual aid societies, they may not universally apply to the organizational processes of shared recovery from mental illness. In applying these lessons to the mental health field, the following question seems apt: What is qualitatively different about mental illness and recovery from mental illness that would influence the ideal structure and process of mutual aid groups? A definitive history of such groups that answers that question has yet to be written.

Recovery Advocacy Movements

There are substantial differences between peer-based recovery movements and recovery advocacy movements. The former focus on the needs of the individual for mutual support of long-term recovery; the latter focus on promoting pro-recovery attitudes, social policies, and recovery-oriented systems of care. The target of advocacy movements, while providing a voice to the experiences and needs of people in recovery that may have therapeutic effects, is primarily the social and political environment rather than the individual. Recovery advocacy provides a means through which people in recovery can confront stigma and its resulting social and institutional obstacles to recovery and shape service systems that reflect their own aspirations and needs. In this section, we will explore the history of recovery advocacy in the addictions field with a particular eye on what this history may offer regarding recovery advocacy within the mental health field.

There is a long history of recovery advocacy in both the addiction and mental health fields. The former range from 19th century patient clubs to the local alcoholism councils of the mid-twentieth century (White, 1998), and the latter span early patient advocates (Elizabeth Packard, Elizabeth Stone, and Clifford Beers) to the rise of an ex-patients' movement in the 1970s (Chamberlin, 1984, 1990, 1995; Frese, 1998; Kaufmann, 1999; McLean, 1995). The re-stigmatization and re-criminalization of the status of addiction in the United States in the 1980s and 1990s has spurred the rise of a New Recovery Advocacy Movement (White, 2000b). In this section, we will describe this movement and compare it to the ex-patient/consumer/survivor movement within the mental health field.

Representative organizations. Organizationally, the New Recovery Advocacy Movement is made up of 1) local affiliates of the National Council of Alcoholism and Drug Dependence (NCADD) who are trying to recapture their advocacy

roots, 2) grantees of the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP), 3) faith-based recovery ministries, 4) abstinence-based cultural revitalization movements in communities of color, and 5) survivor organizations (family members who have lost a loved one to addiction). These organizations are loosely linked through their involvement in various recovery advocacy conferences and the National Faces and Voices of Recovery Campaign (www.facesandvoicesofrecovery.org).

These organizations are the historical counterparts to the National Association of Mental Patients (later the National Association of Psychiatric Survivors), the National Mental Health Consumers' Union, and the earlier noted mutual aid societies (e.g., NAMI) that also function as advocacy organizations.

Membership constituency. While membership in mental health advocacy organizations such as NAMI and local Mental Health Associations has until recently been dominated by family members and professionals, the addiction recovery advocacy movement has been dominated by persons in recovery from addiction. As each of these respective movements mature, its constituencies are expanding, with persons in recovery from mental illness now emerging as a powerful force within the mental health advocacy movement and family members becoming increasingly involved in the New (addiction) Recovery Advocacy Movement.

Membership recruitment. The greatest barrier to recruitment in both the addiction and mental health recovery advocacy movements is fear of the stigma associated with public disclosure of one's recovery status. The addictions field has an added concern about clarifying the potential conflict between the requirement for anonymity within AA and NA and encouragement by advocacy groups to step forward to put a face and a voice on recovery (White, 2000b). Those RCSP grantees, who have worked to organize the (addiction) recovery community over the past five years, have found that considerable groundwork must be laid before significant numbers of people in recovery join or participate in recovery advocacy activities.

Movement goals. The goals of the New Recovery Advocacy Movement are to: 1) portray alcoholism and addictions as problems for which there are viable and varied recovery solutions, 2) provide role models that illustrate the diversity of those recovery solutions, 3) counter attempts to dehumanize, objectify and demonize those with alcohol- and other drug-related problems, 4) enhance the variety, availability, and quality of local/regional treatment and recovery support services, 5) remove environmental barriers to recovery, and 6) promote pro-recovery laws and social policies.

Core values. The values of recovery advocacy organizations are reflected in the core values adopted by the board of Recovery Communities United (RCU) in Chicago:

1) primacy of personal recovery (reminding ourselves that service work alone is not a viable program of addiction recovery),
2) authenticity of voice and representation (empowering recovering people and their family members to express their own needs and aspirations),
3) varieties of recovery experience (respecting varied pathways, styles and stages of recovery),
4) diversity and inclusion (representation of all people in recovery across the boundaries of age, gender, ethnicity, sexual orientation, and problem severity),
5) hope-based interventions (providing "living proof" of the reality of long-term recovery to those in need of recovery, to service professionals, and to the larger community),
6) resilience and recovery (focusing on the strengths of individuals, families and communities),
7) collaboration (community-building between recovering people/families, treatment providers, indigenous healers/institutions, and researchers),
8) recovery community development (building the service and leadership

capacity of recovery community rather than competing, replacing, or otherwise undermining the natural leadership and service ethic of that community), and

9) ethics of mutual support (elevating our ethical sensitivities and decision-making skills within the arena of recovery support services).

Kinetic ideas. In 1942, Dwight Anderson coined a set of "kinetic" ideas (ideas capable of shifting people's attitudes and actions) that were later integrated into the campaign of the National Committee for Education on Alcoholism -- the precursor to today's National Council on Alcoholism and Drug Dependence (Anderson, 1942; Mann, 1944). These ideas were intended to reframe the nature of the problem ("Alcoholism is a disease"), change the perception of those with the problem ("the alcoholics is a sick person"), and posit hope for the problem ("the alcoholic can be helped and is worthy of being helped"). These ideas laid the ideological foundation for modern addiction treatment. A reformulated set of kinetic ideas is emerging within the New Recovery Advocacy Movement. Each idea is designed as an antidote to a prevailing idea within the culture. In response to renewed cultural pessimism about the prospects of recovery, the NRAM is declaring that recovery is a living reality in the lives of hundreds of thousands of individuals, families and communities. Internally, this movement is calling for a vanguard of recovering people to step forward publicly to offer "living proof" of the transformative power of recovery. In response to the idea that there is only one way to recover, the NRAM is declaring that there are many pathways of recovery. In response to a treatment system that has become increasingly coercive, the NRAM is declaring that recovery is a voluntary process. In response to the re-stigmatization and re-criminalization of the status of addiction, the NRAM is declaring that recovery flourishes in supportive communities (White, 2000b). Local recovery advocates across the country are enlisting the support of local policy makers to help create the physical, psychological and social space where the seeds of recovery can be sown and nurtured into maturity. The new recovery advocacy movement is offering its members as evidence that recovery gives back what addiction has taken from individuals, families and communities and that recovering and recovered people are part of the solution (to alcohol and other drug problems).

Core strategies. There are eight strategies that make up the action agenda of (addiction) recovery advocacy organizations.

1. Recovery organization: developing leadership within communities of recovery so that these groups can declare their existence, express their collective voice, and provide a venue for community service.
2. Recovery representation: assuring that the voices of recovering people and their families are included in all venues that address severe and persistent alcohol and other drug problems.
3. Recovery needs assessment: identifying obstacles to recovery, evaluating existing service structures, and prioritizing needed recovery support services.
4. Recovery education: educating lay and professional audiences on the varieties, stages and styles of addiction recovery.
5. Resource development: cultivating volunteerism within the recovery community and expanding philanthropic and public support for recovery support resources.
6. Policy advocacy: championing (through negotiation and social action) stigma-reduction and pro-recovery policies at federal, state, and local levels.
7. Recovery celebration: enhancing the identity and cohesion of local recovery communities, making recovery visible within the larger community, and putting faces and voices on recovery via major media outlets.
8. Recovery research: support of studies to illuminate the strategies, structures and processes associated with long-term recovery.

The experiences of the local organizations that make up the New Recovery Advocacy Movement offer some lessons for their

counterparts within the mental health field.***

First, the specialization and fragmentation of recovery advocacy movements is almost inevitable given the diversity of experiences and varying needs of recovering people and their families, the competition for public attention and limited financial resources, and the threats such movements pose to established mutual aid groups, service professions and service institutions (Kaufmann, 1999). Schisms within advocacy movements reflect different views of addiction and mental illness, different languages used to characterize these conditions, and sometimes radically different visions about the desired alternative to the existing service system. Battles between various advocacy factions may also reflect internalized stigma and the avoidance of confrontation with more powerful forces outside the movement. Such displacement has a long history among social movements of disempowered peoples.

The problems of organizational leadership and structure that have long-plagued recovery mutual aid societies also pose a threat to recovery advocacy organizations. Charismatic leadership and hierarchical structures can undermine the egalitarian, democratic values of these movements and alienate leaders from grassroots constituencies (McLean, 1995). Minimalist approaches to organization and rotating leadership constitute viable antidotes to such tendencies.

Advocacy organizations that evolve into alternative service organizations are vulnerable to losing their advocacy focus as they get caught up with funding requirements and the demands of running a service organization. This happened to many local Councils on Alcoholism in the 1960's and 1970's when funding became available for community-based alcoholism treatment. Advocacy groups that pose a threat to the status and financial interests of service professionals and treatment institutions are often colonized by these institutions via recruitment of leaders into paid roles, pitting moderate groups against more radical groups, and by the theft, dilution and distortion of the language and core concepts of advocacy groups (McLean, 1995).

There is a trend in both the mental health and the addictions field to hire consumers within mainstream service agencies and/or to develop consumer-controlled and operated agencies that provide a wide spectrum of recovery support services. These agencies vary in their philosophies, with some serving as adjuncts to professional treatment and others competing as alternatives to professional treatment. These roles and agencies constitute the emerging service frontier of the mental health and addictions fields and will force a rethinking of many areas of service philosophy, design and delivery. No area within this re-evaluation is likely to be more difficult than the issue of appropriate, ethical boundaries in the relationship between service providers, whether paid or volunteer, and service consumers. Both fields will need to invest substantial energy in redefining such standards as relationship hierarchies collapse and as the line between service provider and service consumer becomes less distinguishable.

Summary

In this chapter, we have tried to explore what has been learned within the addictions and mental health fields about the recovery experience, the role and threats to recovery mutual aid societies, and the nature of recovery advocacy organizations. There are many shared characteristics and themes in recovery from addiction and from mental illness: definitional controversies; the role of self as the "agent of recovery"; levels of recovery (partial, full and transcendent); the variability of pathways, styles and stages of recovery; the roles of recovery debits and recovery capital; the sequencing of change across multiple zones of recovery (physical, intellectual, emotional, relational, rituals of daily life, and spiritual); and the adaptation demands on the family to both illness and recovery. Service work has a distinguished role within the history of recovery, but there are pitfalls as well as promises in the professionalization of such service activities.

Such professionalization must be actively managed to reduce potential harm to the prosumer, other service consumers, the service organization, and local recovery mutual aid and recovery advocacy organizations.

Lessons from the history of addiction recovery mutual aid societies that have salience for other mutual aid groups include the potentially destructive influences of colonization, professionalization, money, property, publicity, and religious/political conflict. The most successful and enduring mutual aid societies maintain their singularity of purpose and closed meeting structure; utilize a flattened, de-centralized organizational structure, regularly rotate leadership at the national and local levels; craft a preferred style of responding to social stigma; and create both a framework ("program") of personal recovery and a set of core values to protect the organization and enhance its future viability.

Recovery advocacy organizations in the addictions and mental health fields share many characteristics (and some subtle differences) in the evolving characteristics of their membership, organizational goals, core values, central ideas, and core strategies. As the addictions and mental health fields are being again pushed toward greater collaboration and integration, the recovery concept seems to be a bridge of shared experience and a vision through which these fields can reach out to one another. Particularly promising are states like Connecticut where human service policy leaders are re-shaping both the addiction and mental health service systems around this recovery vision. We close this investigation believing that there is great potential for positive synergy between these two fields whose histories have been so closely related for more than two centuries, and that the recovery concept may provide a framework for such synergy.

Acknowledgement: Work on this chapter was supported by the Behavioral Health Recovery Management project—a joint venture of Fayette Companies, Chestnut Health Systems and the University of Chicago Center for Psychiatric Rehabilitation funded by the Illinois Department of Human Services' Office of Alcoholism and Substance Abuse.

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Citation: White, W. (2004). Recovery: The next frontier. *Counselor,* 5(1), 18-21.
Posted at **www.williamwhitepapers.com**

Recovery: The Next Frontier

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The history of the addictions field has been one of evolving paradigms (organizing constructs), evolving core technologies and evolving definitions of the field's niche in the larger culture whose needs it must serve. This article traces the evolution of the field's organizing paradigms through three overlapping stages, a problem-focused stage, an intervention-focused stage and an emerging solution-focused stage. These paradigms can be viewed as competing models but are best viewed as developmental stages, with each preparing the emergence of the next.

The Pathology Paradigm

The first stage was launched by what Levine has (1978) christened "the discovery of addiction." This birthing stage in the late eighteenth century was sparked by a break from prevailing moral and religious frameworks of understanding and responding to chronic drunkenness. Compulsive and destructive AOD use became defined as a disease of the body and the will, a redefinition that has sustained more than 200 years of research on the nature of psychoactive drugs, their acute and chronic effects, the multiple sources of individual vulnerability to AOD problems, and the stages of AOD problem development. An enormous body of literature exists and continues to be generated on the psychopharmacology and epidemiology of AOD problems. Elaborate systems of data collection exist to measure the slightest shifts in drug-related attitudes, beliefs, and behaviors. A research industry exists whose sole mission is studying drugs, their patterns of consumption, and their personal and social costs. As a culture and a professional field, our knowledge of psychoactive drugs and drug addiction is impressive. This cultural investment in studying the nature of AOD problems reflects a pathology paradigm—the assumption that knowledge of the sources of a problem will lead to its eventual solution. Knowledge gained within this paradigm provided significant benefits and laid the foundation for policy, educational and clinical responses to AOD problems.

The Intervention Paradigm

Attempts to personally and socially resolve AOD problems also have a long history in America. These attempts span AOD-related social policies, education and prevention efforts, early intervention programs and addiction treatment. A voluminous body of knowledge and resources (including this journal) exists that focus on when and how to intervene in these problems. The readers of this journal have been part of this country's unprecedented investment in the professionally-directed treatment of AOD problems. Some readers are old enough to have witnessed the transition of treatment from an unfunded folk art to a highly professionalized and commercialized industry. We have learned within this modern era of treatment how to interrupt addiction careers. We know a lot about engagement, detoxification, problem stabilization, and recovery initiation. We know a lot about what people look like in the years before they were admitted to treatment. We know a lot about what people look like during treatment. And we know a little bit about what people look like in the months following treatment.

The knowledge gained from this intervention paradigm has advanced the field and allowed hundreds of thousands of individuals to initiate and sustain recovery. The majority of drug dependent persons who achieve sustained recovery do so after participating in treatment (the percentage varies by substance: cannabis (43%), cocaine (61%), alcohol (81%) and heroin (92%) (Cunningham et al., 1999, 2000). That knowledge has also illuminated the limitations of our current treatment system. For persons with severe AOD problems, it often takes three to four episodes of acute treatment over a span of eight years to achieve stable and enduring recovery (Dennis, Scott, Funk & Foss, under review). These findings challenge models of brief treatment, short-term aftercare, and follow-up studies whose designs, until recently, extended only several months following discharge from treatment. These shortcomings have led to calls for more recovery-sustaining models of intervention and support and more recovery-focused research and evaluations activities. In short, there is growing interest in extending the pathology and intervention paradigms into a more fully developed recovery paradigm.

Agitation for Change

For readers who think they and their program and the larger field are already recovery-focused, it may be helpful to view this issue through the eyes of the recovery advocates (of the 1950s-1960s) who were the midwives of modern addiction treatment. It is among these advocates that the need and call for this recovery paradigm is most poignantly articulated. The advocacy leaders in local alcoholism and "drug abuse" councils were inspired by a vision of an ever-expanding recovery community. They championed the birth of professionally-directed treatment as a special doorway of entry into that community for the many people who could not make the transition from addiction to recovery on their own. Decades later, these advocates see an ever-growing treatment industry that views recovery as an afterthought or adjunct of itself. While this view may seem harsh to the readers of Counselor, consider the world through their eyes. They see "addiction studies" curricula in colleges and universities but no "recovery studies" curricula. They see scientific journals whose names reflect an interest in alcohol and other drugs (e.g., *Journal of Studies on Alcohol*, *Journal of Psychoactive Drugs*, *Addiction*, *Contemporary Drug Problems*) and professional intervention into AOD problems (e.g., *Journal of Substance Abuse Treatment*, *Alcoholism Treatment Quarterly*), but they see no peer-reviewed journals focused on the scientific study of addiction recovery. They read innumerable studies that meticulously describe who uses which psychoactive drugs and with what consequences, but see only a few recovery prevalence studies. They confront the public perception that people do not recovery despite rarely acknowledged epidemiological studies finding that 58% of

people with lifetime substance dependence eventually achieve sustained recovery (Kessler, 1994; see also Dawson, 1996; Robins & Regier, 1991). They see national institutes of "alcohol abuse and alcoholism" and "drug abuse" and national centers of "substance abuse prevention" and "substance abuse treatment" but they see no "national institute/center of addiction recovery." They see "addiction technology transfer centers" but no "recovery technology transfer centers." In short, they see a field that knows a lot about addiction and a lot about treatment but which they perceive to have lost its focus on the goal and processes of long-term recovery.

These advocates are joining with visionary policy leaders, treatment professionals, and the addictions researchers to shift the field's kinetic ideas and slogans from the nature of the problem ("addiction is a disease") and the alleged effectiveness of its interventions ("treatment works") to the living proof of a permanent solution to AOD problems ("recovery is a reality"). Collectively, these voices are saying that it is time to use the foundations laid from the study of the problem and its treatment to build a fully developed recovery paradigm.

The Recovery Paradigm

The movement forward to a recovery paradigm is already underway. The evidence of this shift in grassroots communities includes the:

- growth and diversification of American communities of recovery (White, in press)
- emergence of a multi-branched new recovery advocacy movement (White, 2001)
- rapidly spreading Wellbriety movement in Indian Country (see www.whitebison.org)
- growth of faith-based recovery support structures, particularly within communities of color (see Sanders, 2002)
- organization of recovering ex-felons into mutual support networks, (e.g., the Winners Circle in Chicago)
- growth of self-managed recovery homes (see http://www.oxfordhouse.org) and recovery schools (e.g., the Association of Recovery Schools), and the
- spread of recovery employment coops (e.g., Recovery at Work in Atlanta).

The shift to a recovery paradigm is evident at the federal level in President Bush's Access to Recovery Initiative, increased NIDA and NIAAA support for studies of long-term recovery, and CSAT's Recovery Community Support Program and Recovery Month initiatives. It is evident in state initiatives pushing treatment toward a "recovery-oriented system of care" (see **http://www.dmhas.state.ct.us/policies/policy83.htm).** It is evident in the research community's call to shift addiction treatment from serial episodes of acute intervention to models of sustained "recovery management" (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002, 2003). And it is evident in local experiments with peer-based models of recovery support, new recovery-focused service roles (recovery coaches, recovery support specialists), and the shift from traditional "aftercare" services to models of "assertive continuing care" (White & Godley, 2003; Dennis, Scott & Funk, 2003).

Recovery Management

How will the transition toward a recovery-focused future differ from our past? The shift from acute intervention to recovery management for those persons with severe and persistent AOD problems will involve three changes in the continuum of care.

First, it will intensify pre-treatment recovery support services to strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, and determine whether the individual/family can initiate and sustain recovery at this stage without additional professional intervention. (The latter may be quite possible for those with lower problem

severity and indigenous supports for recovery.)

Second, recovery management will intensify in-treatment recovery support services to enhance treatment retention and effects (by keeping treatment recovery-focused). Traditional treatment methods will change in a number of important dimensions (e.g., from single-agency to multi-agency intervention, from categorical to global assessment, from institution-based to neighborhood- and home-based service delivery). Most importantly, it will differ in the nature and duration of the service relationship.

Third, recovery management will shift the focus of treatment from acute stabilization to support for long-term recovery maintenance. Professionally-directed recovery management, like management of other chronic health disorders, shifts the focus of care from one of admit, treat, and discharge to a sustained health management partnership.

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New paradigms bring new ways of perceiving, thinking and speaking. As we move deeper into this recovery paradigm, we will need to forge new concepts and a new language. We will need better words and concepts to:

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We will all need to stretch our understanding of recovery and become multilingual as we expand the words and metaphors that reflect the growing varieties of recovery experiences in America.

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Since its inception, the purpose of this column has been to enhance the addiction professional's understanding of the history of treatment and recovery in America. This article is about the living history that is unfolding before us in this moment. It is about the opportunity for recovery advocates, policy leaders, treatment professionals and researchers to form a partnership that will write the future of history of addiction treatment and recovery in America. Destiny will call some of you reading this to help lead this leap into the future. I wish you and your clients Godspeed on your journey from the problem we know so well to the recovery vision that lies ahead of us.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2004). Recovery: The next frontier. *Counselor,* 5(1), 18-21.
Posted at **www.williamwhitepapers.com**

Recovery: The Next Frontier

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The history of the addictions field has been one of evolving paradigms (organizing constructs), evolving core technologies and evolving definitions of the field's niche in the larger culture whose needs it must serve. This article traces the evolution of the field's organizing paradigms through three overlapping stages, a problem-focused stage, an intervention-focused stage and an emerging solution-focused stage. These paradigms can be viewed as competing models but are best viewed as developmental stages, with each preparing the emergence of the next.

The Pathology Paradigm

The first stage was launched by what Levine has (1978) christened "the discovery of addiction." This birthing stage in the late eighteenth century was sparked by a break from prevailing moral and religious frameworks of understanding and responding to chronic drunkenness. Compulsive and destructive AOD use became defined as a disease of the body and the will, a redefinition that has sustained more than 200 years of research on the nature of psychoactive drugs, their acute and chronic effects, the multiple sources of individual vulnerability to AOD problems, and the stages of AOD problem development. An enormous body of literature exists and continues to be generated on the psychopharmacology and epidemiology of AOD problems. Elaborate systems of data collection exist to measure the slightest shifts in drug-related attitudes, beliefs, and behaviors. A research industry exists whose sole mission is studying drugs, their patterns of consumption, and their personal and social costs. As a culture and a professional field, our knowledge of psychoactive drugs and drug addiction is impressive. This cultural investment in studying the nature of AOD problems reflects a pathology paradigm—the assumption that knowledge of the sources of a problem will lead to its eventual solution. Knowledge gained within this paradigm provided significant benefits and laid the foundation for policy, educational and clinical responses to AOD problems.

The Intervention Paradigm

Attempts to personally and socially resolve AOD problems also have a long history in America. These attempts span AOD-related social policies, education and prevention efforts, early intervention programs and addiction treatment. A voluminous body of knowledge and resources (including this journal) exists that focus on when and how to intervene in these problems. The readers of this journal have been part of this country's unprecedented investment in the professionally-directed treatment of AOD problems. Some readers are old enough to have witnessed the transition of treatment from an unfunded folk art to a highly professionalized and commercialized industry. We have learned within this modern era of treatment how to interrupt addiction careers. We know a lot about engagement, detoxification, problem stabilization, and recovery initiation. We know a lot about what people look like in the years before they were admitted to treatment. We know a lot about what people look like during treatment. And we know a little bit about what people look like in the months following treatment.

The knowledge gained from this intervention paradigm has advanced the field and allowed hundreds of thousands of individuals to initiate and sustain recovery. The majority of drug dependent persons who achieve sustained recovery do so after participating in treatment (the percentage varies by substance: cannabis (43%), cocaine (61%), alcohol (81%) and heroin (92%) (Cunningham et al., 1999, 2000). That knowledge has also illuminated the limitations of our current treatment system. For persons with severe AOD problems, it often takes three to four episodes of acute treatment over a span of eight years to achieve stable and enduring recovery (Dennis, Scott, Funk & Foss, under review). These findings challenge models of brief treatment, short-term aftercare, and follow-up studies whose designs, until recently, extended only several months following discharge from treatment. These shortcomings have led to calls for more recovery-sustaining models of intervention and support and more recovery-focused research and evaluations activities. In short, there is growing interest in extending the pathology and intervention paradigms into a more fully developed recovery paradigm.

Agitation for Change

For readers who think they and their program and the larger field are already recovery-focused, it may be helpful to view this issue through the eyes of the recovery advocates (of the 1950s-1960s) who were the midwives of modern addiction treatment. It is among these advocates that the need and call for this recovery paradigm is most poignantly articulated. The advocacy leaders in local alcoholism and "drug abuse" councils were inspired by a vision of an ever-expanding recovery community. They championed the birth of professionally-directed treatment as a special doorway of entry into that community for the many people who could not make the transition from addiction to recovery on their own. Decades later, these advocates see an ever-growing treatment industry that views recovery as an afterthought or adjunct of itself. While this view may seem harsh to the readers of Counselor, consider the world through their eyes. They see "addiction studies" curricula in colleges and universities but no "recovery studies" curricula. They see scientific journals whose names reflect an interest in alcohol and other drugs (e.g., *Journal of Studies on Alcohol*, *Journal of Psychoactive Drugs*, *Addiction*, *Contemporary Drug Problems*) and professional intervention into AOD problems (e.g., *Journal of Substance Abuse Treatment*, *Alcoholism Treatment Quarterly*), but they see no peer-reviewed journals focused on the scientific study of addiction recovery. They read innumerable studies that meticulously describe who uses which psychoactive drugs and with what consequences, but see only a few recovery prevalence studies. They confront the public perception that people do not recovery despite rarely acknowledged epidemiological studies finding that 58% of

people with lifetime substance dependence eventually achieve sustained recovery (Kessler, 1994; see also Dawson, 1996; Robins & Regier, 1991). They see national institutes of "alcohol abuse and alcoholism" and "drug abuse" and national centers of "substance abuse prevention" and "substance abuse treatment" but they see no "national institute/center of addiction recovery." They see "addiction technology transfer centers" but no "recovery technology transfer centers." In short, they see a field that knows a lot about addiction and a lot about treatment but which they perceive to have lost its focus on the goal and processes of long-term recovery.

These advocates are joining with visionary policy leaders, treatment professionals, and the addictions researchers to shift the field's kinetic ideas and slogans from the nature of the problem ("addiction is a disease") and the alleged effectiveness of its interventions ("treatment works") to the living proof of a permanent solution to AOD problems ("recovery is a reality"). Collectively, these voices are saying that it is time to use the foundations laid from the study of the problem and its treatment to build a fully developed recovery paradigm.

The Recovery Paradigm

The movement forward to a recovery paradigm is already underway. The evidence of this shift in grassroots communities includes the:

- growth and diversification of American communities of recovery (White, in press)
- emergence of a multi-branched new recovery advocacy movement (White, 2001)
- rapidly spreading Wellbriety movement in Indian Country (see www.whitebison.org)
- growth of faith-based recovery support structures, particularly within communities of color (see Sanders, 2002)
- organization of recovering ex-felons into mutual support networks, (e.g., the Winners Circle in Chicago)
- growth of self-managed recovery homes (see http://www.oxfordhouse.org) and recovery schools (e.g., the Association of Recovery Schools), and the
- spread of recovery employment coops (e.g., Recovery at Work in Atlanta).

The shift to a recovery paradigm is evident at the federal level in President Bush's Access to Recovery Initiative, increased NIDA and NIAAA support for studies of long-term recovery, and CSAT's Recovery Community Support Program and Recovery Month initiatives. It is evident in state initiatives pushing treatment toward a "recovery-oriented system of care" (see **http://www.dmhas.state.ct.us/policies/policy83.htm).** It is evident in the research community's call to shift addiction treatment from serial episodes of acute intervention to models of sustained "recovery management" (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002, 2003). And it is evident in local experiments with peer-based models of recovery support, new recovery-focused service roles (recovery coaches, recovery support specialists), and the shift from traditional "aftercare" services to models of "assertive continuing care" (White & Godley, 2003; Dennis, Scott & Funk, 2003).

Recovery Management

How will the transition toward a recovery-focused future differ from our past? The shift from acute intervention to recovery management for those persons with severe and persistent AOD problems will involve three changes in the continuum of care.

First, it will intensify pre-treatment recovery support services to strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, and determine whether the individual/family can initiate and sustain recovery at this stage without additional professional intervention. (The latter may be quite possible for those with lower problem

severity and indigenous supports for recovery.)

Second, recovery management will intensify in-treatment recovery support services to enhance treatment retention and effects (by keeping treatment recovery-focused). Traditional treatment methods will change in a number of important dimensions (e.g., from single-agency to multi-agency intervention, from categorical to global assessment, from institution-based to neighborhood- and home-based service delivery). Most importantly, it will differ in the nature and duration of the service relationship.

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Citation: White, W. & Scott, C. (2004). The role of community in addiction recovery. Posted at **www.williamwhitepapers.com**

The Role of Community in Addiction Recovery

William L. White, M.A., and Christy K. Scott, PhD
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We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.
--Sandra Bloom, *Creating Sanctuary*

Addiction treatment in the modern era has been practiced as an essentially biopsychological intervention. Its central activities have often focused on sequestering the addicted individual from his or her family and cultural environment and attempting to alter the biological states and psychological attributes believed to constitute the etiological roots of alcohol and other drug (AOD) problems. Socio-cultural models of intervening with AOD problems at a personal level have existed in recent decades at the periphery of the treatment field (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998), or have arisen as religious or social movements outside the professional world of addiction treatment (Williams & Laird, 1992).

This near-exclusive focus on the vulnerabilities and resiliencies of the individual has not always dominated the AOD problems arena. There are episodes in the history of addiction treatment and recovery in which one finds a much greater emphasis on the ecology of addiction and recovery. Such episodes reflect models of community resource development and mobilization that could serve as alternatives and adjuncts to today's clinical models of intervention.

This chapter explores the power of community within the processes of addiction recovery. Our intent is not to impugn models of understanding and resolving alcohol and other drug (AOD) problems that focus primarily upon biological or psychological vulnerabilities. It is rather to offer a reminder that these dimensions of vulnerability and methods of intervention exist within particular physical, family and cultural environments that exert their own profound influence on the vulnerability for addiction and the potential for recovery. We will contend that: 1) the health of individuals, families and communities are inseparable, 2) communities constitute an underutilized resource of recovery support, and that 3) professionalized system of intervention into AOD problems need to be closely linked to indigenous systems of support within local communities where such support exists, and organized and mobilized where it does not exist. We will talk about "community" at multiple and overlapping levels: family, kinship and social networks; neighborhood- and local community-based cultures of

addiction and recovery (the physical and cultural environments within which addiction and recovery are initiated and sustained); local communities and their institutional economies (from illegal markets to local service institutions) and the macro-culture of attitudes and values that shape the prevalence and character of addiction and recovery.

Recovery, Community, History

We begin this exploration with a brief discussion of the role of community in addiction recovery as viewed within critical periods in the history of addiction recovery mutual aid societies and addiction treatment institutions. Addiction recovery mutual aid societies have existed in America for more than 200 years (Humphreys, 2004, White, 2004b). Contrasting views of the role of community and recovery are illustrated in a comparison of Native Americana and Euro-American recovery support structures.

Abstinence-based religious and cultural revitalization movements in Native America from the Delaware Prophets, Handsome Lake, the Shawnee Prophet, the Kickapoo Prophet, and the Native American and Indian Shaker Churches through the contemporary Red Road and Wellbriety movements) have portrayed colonization and cultural decay as a root of addiction, and cultural and community renewal as its most potent antidote. In this view, colonization and oppression, the destruction of cultural history and traditions, lost tribal identity and cohesion, and the resulting disintegration of family constitute the essential etiological agents in the rise of alcohol and other drug problems in Native American. The resolution of alcohol and other drug problems at an individual level are seen as inseparable from the repair and renewal of the family and the tribe (Coyhis and White, 2003; Coyhis, White and Simonelli, forthcoming). This broader view of the sources and solutions to AOD problems has continued within American communities of color (White and Sanders, 2004).

In contrast, recovery movements within Euro-American communities have lacked this ecological perspective on the sources of alcohol and other drug problems, but have conveyed the importance of community in recovery. From the Washingtonians through Alcoholics Anonymous and its adjuncts and alternatives, there have been two consistent messages: 1) recovery involves a reconstruction of personal identity and interpersonal relationships, and 2) this personal and interpersonal transformation is best achieved in relationship to a community of recovering people.

Disagreements about the role of community in recovery were common among the founders of America's first addiction treatment institutions. Those who pioneered nineteenth century inebriate asylums viewed the family and community as an enemy of recovery; advocated prolonged, legally enforced sequestration of addicts from community life; and discouraged contact between addicts and their families and social networks during treatment. In contrast, inebriate homes and the religiously-oriented urban missions and rural inebriate colonies sought to immerse those seeking recovery in a community of shared commitment and reciprocal support. The private addiction cure institutes similarly encouraged their patients to fully participate in community life during treatment and to participate in institutional support groups (e.g., the Keeley Leagues) upon their return home (White, 1998; White and Savage, 2003).

The rise of modern addiction treatment was marked by a polarization of thinking about community and recovery. The 1960s and 1970s saw two competing paradigms. The winning paradigm defined AOD problems as a biopsychological phenomenon: a diagnosable medical disorder requiring professional intervention. Such interventions focused on reversing the individual's physical adaptations to the drug (withdrawal, craving) and altering addiction-related patterns of thinking, feeling and behaving. The approach emphasized case-finding, clinical screening and assessment, medical and psychological treatment of the individual, and brief aftercare services--all

provided by clinically trained professionals. This individualized conception of AOD problems and their solution provided the foundation for the legitimization and industrialization of modern addiction treatment in America. The biopsychological model became so dominant that there is only fading memory of its alternative.

During the 1960s and early 1970s, an alternative to the clinical model of addiction treatment was pioneered within several states and within the alcoholism programs of the federal Office of Economic Opportunity (OEO). This model focused on building capacity to address alcohol problems not within a treatment center but within the larger community. Counselors in this model were trained in community development skills with an emphasis on using indigenous recovery support structures such as Alcoholics Anonymous rather than trained in clinical skills (NAADAC..., 1992). What was most distinctive within OEO was the belief that alcoholism programs had to be built on the needs of, and ultimately controlled by, alcoholics and their families (Renaud, 1982). The OEO and selected state programs sought to do two things: 1) undermine the forces in the community that contributed to AOD problems, and 2) create space within the community where recovery could flourish.

Harold Mulford extensively documented the philosophy of this early model in Iowa. The role that was at the center of the Iowa model was not a counselor, but a "Community Alcoholism Agent" (CAA) who served as a case-finder, motivator, educator, advisor and friend to the alcoholic and an educator and resource mobilizer in the community. The goal was to get as many people as possible involved in the alcoholic's recovery (Mulford, 1976). This model, which relied to a great extent on volunteer support, fell out of favor in the 1970s amidst calls to address alcohol problems with greater organization, skill, and financial resources. In that rising tide of professionalization, voluntarism within the addiction problem arena declined and was replaced by an ever-growing class of paid helpers whose focus shifted from the community to the clinic and the intrapersonal experiences of those with AOD problems.

It can be seen from this brief review that these lay recovery movements and professional treatment movements had diverse views about whether addiction recovery was something that emerged from within the self, was something that was done to the addicted individual by treatment professionals, or something that was experienced in the context of the addict's relationship with a recovering community. The pendulum of emphasis in addiction treatment is currently shifting from a focus on the individual to a rediscovery of the community environment. This shift is evident in calls to: 1) transform the clinical model of addiction treatment into more community-focused "recovery-oriented system of care" (see DMHAS, 2004), 2) shift addiction treatment from an institution-based model of acute intervention to a community-based model of sustained "recovery management" (White, Boyle and Loveland, 2003), and 3) growing interest in peer-based recovery support services (White, 2004a). This heightened interest in the role of community in recovery is further evident in President Bush's recently announced Access to Recovery program and the expansion of the Center for Substance Abuse Treatment's Recovery Community Support Program.

The Ecology of Recovery: Key Principles

There are several key principles and observations that are emerging in this renewed exploration of community as a catalyst and support for addiction recovery. In this section, we will briefly discuss some of these propositions.

Changing Community Context

Growing numbers of individuals are experiencing social disconnection, isolation and a loss of social identity and life-shaping social norms. This alienation and anomie is the product of escalating changes in nuclear family structure; decreased quantity and quality of contact with extended family and kinship networks; the loss of socially intimate, value-homogenous neighborhoods; and weakening attachment

to primary social institutions, e.g., schools, workplaces, churches (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). In the face of these changes, there are calls for "community building"—creating or strengthening healing environments--as a strategy for resolving a wide variety of personal problems (Jason & Kobayashi, 1995). The surging interest in family and community within the addictions field reflects more global preoccupations with the health and healing potential of families and communities. *Existing institutions are being transformed and new social structures are emerging to perform what have historically been family functions.* Schools, workplaces, and social agencies have all absorbed a growing list of functions once performed by family members and extended family members. Alternative social structures from gangs to self-help groups are also taking over functions historically performed by families.

Community as an Etiological *Agent* *The experience of community can be pathogenic (wounding, deforming) or salugenic (healing, wholeness-generating).* When community infrastructures decay, there are widening physical, psychological and social spaces where sickness can rapidly spread. Coyhis (1999) has referred to such spaces as the diseased soil of community life. *Cultures of addiction, with their own history, traditions, language, values, and rituals flourish in wounded communities* (White, 1996). These cultures meet a wide variety of needs of individuals disaffiliated from families and mainstream social institutions. People can become as dependent upon these cultures (and the identity and affiliation needs met there) as upon the drugs that are the central sacraments of these cultures. *Within besieged communities, personal sobriety and survival may be inseparable from the sobriety and survival of the larger community*. In such communities, the individual draws nourishment from a healthy community just as the sobriety and service of the individual feeds that community. Where the addiction of individuals constitutes a manifestation of the wounds of a larger community, both the individuals and the community require treatment (Brave Heart, 2003). There are vibrant examples of such simultaneous personal recovery and community revitalization (see Williams and Laird, 1992).

Community as an Obstacle to Recovery C*ommunities can pose specific obstacles to addiction recovery by failing to provide the physical, psychological and social space where recovery can be initiated and by failing to provide escape routes into that alternative world*. Escalating pain precipitates recovery initiation only in the presence of hope, and that hope often springs from resources and relationships outside the self. Communities constitute an obstacle to recovery as long as they allow cultures of addiction to flourish, provide no visible role models for long-term recovery, and provide no visible pathways to recovery.

Limitations of Biopsychological Treatment While many people's lives have been transformed by addiction treatment, such treatment as currently delivered is limited in what it can achieve. Even with the coercive influence of multiple systems, addiction treatment is able to attract only ten percent of persons in need of such services (SAMHSA, 2003). The current system relies almost completely on the pain of natural consequences to bring those with AOD problems into treatment. If we were really serious about treating addiction, we would send teams of recovery messengers/recruiters into the very heart of local drug cultures. Less than half of those admitted to addiction treatment successfully complete treatment (SAMHSA, 2002), and there is no system of post-treatment monitoring and early re-intervention for non-completers. Many of those completing treatment receive less than the optimal dose of treatment prescribed by the National Institute on Drug Abuse (1999). Post-treatment continuing care services enhance recovery outcomes, but only 20% of clients discharged from addiction treatment receive any significant dose of such services (McKay, 2001). Similarly, post-treatment mutual aid society participation enhances long-term recovery outcomes, but there is

high attrition in such participation following treatment (Mäkelä, Arminen, Bloomfield, Eisenbach-Stangl, Bergmark, Kurube, et al., 1996). There are high rates of post-treatment relapse and re-admission. Sixty percent of persons admitted to addiction treatment in the U.S. already have one or more prior episodes of treatment (SAMHSA, 2002). *Without community supports to engage people at an early stage of problem development, enhance treatment completion, link people to indigenous recovery support systems and provide post-treatment monitoring and early re-intervention, addiction treatment in the United States will continue to operate as an emergency room whose cyclical episodes of biopsychological stabilization will fail to generate long-term recovery in the community for the majority of people with severe AOD problems.*

Coyhis (1999) suggests that temporarily transplanting sick trees, nurturing them back to health and then replanting them in the original diseased soil from which they were removed makes little sense. He argues that we must treat the wounded individuals and the diseased soil of community life by treating the community as well as its members—by creating a healing forest. It is in this way that the community becomes simultaneously a recipient of treatment and an instrument of recovery initiation and maintenance.

Isolation of Treatment from Community *The greater the physical and cultural distance between the treatment center and the natural environment of the person being treated, the less the transfer of learning from the former to the latter.* Prolonged sequestration of people with AOD problems in the name of treatment injures those being treated (by rooting their recovery to an institution rather than to a natural network of relationships in the community), injures treatment agencies (by promoting closed, incestuous systems prone to implosion, e.g., Synanon), and injures the community by failing to develop natural recovery support systems that are sustainable and non-commercialized.

Recovery Stability/Durability and Community *Professional support for recovery from addiction should be sustained until the individual/family recovery process can be sustained on its own momentum in the individual/family's natural community.* The period of recovery durability (the point at which future risk of relapse in one's lifetime drops below 15%) following treatment for alcoholism is reached between 4-5 years of sustained recovery (Jin, Rourke, Patterson, Taylor, & Grant, 1998)--longer for recovery from opiate addiction (Hser, Hoffman, Grella, & Anglin, 2001). Building systems of support for recovery maintenance will require creating connecting tissue between treatment institutions and the community environments in which there clients live. We are not proposing that primary treatment be sustained indefinitely, but we are suggesting the utility of assertive continuing care in the community, e.g., post-treatment monitoring and support, stage-appropriate recovery education, active linkage to local communities of recovery, recovery community resource development and early re-intervention. Such sustained recovery support services could transition from a level of high intensity during the first 90 days following primary treatment (the period of highest risk for post-treatment relapse) to low intensity but sustained monitoring, e.g., recovery checkups (See Dennis, Scott, & Funk, 2003) as recovery supports shift from the institutional environment to the community environment.

Community as an Agent of Healing Like addiction, recovery is mediated by processes of social engagement and support (See McCrady, 2004 for an excellent review). *Cultures (communities) of recovery, with their own history, traditions, language, values, and rituals flourish in communities that welcome them* (White, 1996). There is no single "recovery community," but a growing diversity of "communities of recovery" that differ significantly in their membership characteristics and in their philosophies and support technologies (Kurtz & Kurtz, 2004). The primary purpose of these micro-communities (communities within a community) is to support individuals

and families through the developmental stages of addiction recovery. Within these communities of recovery, people with severe AOD problems experience a sense of being at home--of being at the one place where one's absence would be missed. Communities of recovery are places of sanctuary and healing for those who have been stigmatized and marginalized by their addiction careers. There one is accepted not in spite of one's imperfectness, but because of the very nature of that imperfection. Communities of recovery are places of refuge, refreshment and renewal, whether they exist in the meeting rooms of churches or in the virtual world of the Internet. For many people, recovery from addiction is a journey between two physical and social worlds—a movement from the toxic world of drug dependency to a healthy "prodependency on peers" (Nealon-Woods, Farrari and Jason, 1995). *Strategies that enhance family and community cohesion and nurture the development of healing networks within the larger community may serve to prevent AOD problems as well as facilitate problem identification and resolution*.

Styles of Recovery Affiliation Not all people in recovery relate to these communities of recovery in the same way. There are *acultural styles* of addiction/recovery (no affiliation with other addicted/recovering people), *bi-cultural styles* of recovery (balanced association with an addiction/recovery community and the larger community), and *enmeshed styles* of recovery (immersion in a culture of addiction/recovery with little contact with civilians—persons without addiction or recovery experience). *Persons with an enmeshed style of addiction often require an enmeshed style of recovery initiation* (White, 1996). Discharging clients from addiction treatment into drug-saturated family and social environments is a recipe for relapse. What is called for is the development of strong local cultures of recovery that can compete with, insinuate their way into, and eventually transform these toxic environments.

Potential Iatrogenic Effect of Social Interventions *Professional interventions into health and social problems may through their design either weaken or strengthen the community's natural capacity for support.* John McKnight (1985) argues that the proliferation of helping agencies over the past half century generated the unintended effect of undermining and hastening the dissolution of traditional support provided by families, extended families, neighborhoods, churches, labor unions, and whole communities. He contends that as a country we suffer, not from a lack of professionally-directed service agencies, but from a lack of community. To the extent that responsibility for caring for those with the most severe AOD problems passed from families and indigenous community institutions (schools, churches, voluntary mutual aid groups) addiction treatment professionals, the treatment field may have inadvertently contributed to the abandonment of these individuals by the community. There is a growing population of addiction treatment recidivists who are estranged from family, friends and community, who are not accepted members of local communities of recovery, and who seem to be trapped within the limbo world of addiction treatment. It is time we helped with their reintegration or built alternative communities to support their recoveries.

Community Building and the Community Guide McKnight (1995) advocates the creation of "community guides" who move wounded citizens, not toward enmeshment with professional helpers and their institutions, but toward deeper involvement in the problem-solving and healing resources within the larger community*. The goal of community building is to replace, to the greatest extent possible, relationships that are transient, hierarchical, and professionalized with relationships that are enduring, equal, and reciprocal.* The goal is to support long term recovery by nesting this recovery in communities defined not by geography but by shared experience, shared identity, shared need, shared hope, and shared support.

Strategies for Community Building *The field of addiction treatment can tap the healing power of communities of recovery* by focusing on six zones of activity.

- *Knowledge Development*: enhancing the treatment organization's understanding of the growing diversity of American communities of recovery by involving professional staff within the life of these communities.
- *Role Redefinition*: including the function of recovery community resource development and mobilization.
- *Community Involvement*: increasing collaboration with indigenous sobriety-based support structures and other indigenous healers and institutions.
- *Recovery Resource Development*: playing an active role in the development of local recovery support groups and recovery support services.
- *Consumer Involvement*: Involving recovering people and their family members in the planning, design, delivery, and evaluation of treatment services.
- *Identity Reconstruction*: Exploring the implications of this new community partnership on the treatment organization's mission, core values, service menu, service roles, and the ethical standards governing relationships between staff and service consumers (White, 2002).

Peer-based Recovery Support Services (P-BRSS) There are a growing number experiments with peer-based recovery support services as an adjunct and alternative to addiction treatment. The roles—both paid and voluntary--that are at the center of these service models go by varied names: recovery coach, recovery mentor, peer counselor, recovery support specialist. Some states (CT, AZ) are systematically including P-BRSS as part of a reconfigured continuum of addiction treatment services care, and at least one state (PA) is already investigating the credentialing of recovery support specialists. What these experiments share in common is the use of P-BRSS specialists to reconnect treatment to the larger and more enduring process of recovery and to build connecting tissue between the service recipients, the treatment institution, local communities of recovery and the larger community in which the processes of recovery must be anchored (White, 2004a).

Potential Pitfalls

This proposed integration of clinical and community development models is not without its pitfalls. The functions require fundamentally different skills than the skills required for clinical roles and may be best delivered out of different organizational contexts. There are no existing funding streams to support recovery community resource development and the advocacy activities that are often implicit in such resource development. There exists a danger that the natural service ethic within communities of recovery will be weakened by the likely professionalization of recovery support services. The ethical guidelines for clinical roles will not easily transfer to recovery support and community organization activities, and there are few alternative guidelines for the management of ethical dilemmas within non-clinical activities. At a broader level, the community's capacity for compassion and caretaking is open to question, particular in problem-plagued communities that are being asked to care for traditionally stigmatized populations. That capacity for compassion and caretaking will have to be tested one community and one individual at a time.

Summary and Conclusions

The role of community in recovery has been viewed quite differently across the history of recovery mutual aid societies and within the professional world of addiction treatment. The modern emphasis on addiction and recovery as biopsychological processes is giving way to a greater

appreciation of the role of social and cultural processes in the development and resolution of AOD problems. This shift rests on the recognition of the changing nature of communities, the role of community decay as a contributing source of AOD problems, the role of community support as an agent of healing, the need to nurture sustainable community-based recovery support systems, and the need to build recovery-oriented systems of care that extend recovery support services from the treatment institution to the natural environments of the clients being treated.

There is a growing sense that addiction treatment has become disconnected from its historical roots, detached from the larger and more enduring

Treatment organization that in their earliest years defined themselves as "community-based" are more likely today to define themselves as businesses. To recapture that founding identity, agencies must find ways to rejoin their communities and discover the natural healing powers that lie within these communities. By narrowly defining the sources of AOD problems within biomedical models, we have restricted our vision of the potential solutions to these problems. Perhaps it is time we rediscovered what was of value along that road the addictions field did not take in the transition from the 1960s to the 1970s. When universities became too isolated from the communities in which they were born, progressive educators called for these institutions to move back into the life of their communities--to become universities without walls. It is time we forged a system of addiction treatment and recovery without walls. Barriers to recovery and incentives for recovery exist in the community space surrounding those experiencing severe AOD problems. It is that space that marks the new (rediscovered) frontier for addiction treatment professionals.

Acknowledgement: Support for this article was provided by grants from the National Institute on Drug Abuse (Grant R01 DA15523 and Grant R01 DA014409). The opinions expressed here are those of the

process of addiction recovery, and divorced from the grass roots communities out of which it was born. As the field evolved into a clinical specialty, it lost touch with its role as an active agent in enhancing the healing power of community. In spite of significant new clinical technologies, addiction treatment suffers from a loss of such core functions as community education, social action, and community resource development, mobilization and linkage. Our focus should be not just on what professionalized services we can offer members of our local communities, but on how we can develop resources within these communities that diminish the need for professionalized structures of care and support.

authors and do not reflect the opinions or policies of any governmental agency.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2004). Substance use and violence: A brief primer for addiction professionals. *Addiction Professional,* 2(1): 13-19. Posted at **www.williamwhitepapers.com**

Substance Use and Violence: A Brief Primer for the Addictions Professional

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Addiction professionals are frequently called upon to assess and treat individuals with histories of excessive alcohol and other drug use and interpersonal violence. The formula P (person) + D (drug) + E (environment) =V (violence) depicts the multiple factors that can interact to influence the risk of violence, but there is a high degree of variability in how these factors interact.

In the person-drug-environment interaction, many factors determine whether the threshold between an impulse to commit violence and the act of violence is crossed. Within the P component are such influences as developmental history, prior history of aggression, personality, current mental status, type and degree of social support, and values. The D factors vary by particular drug or drug combination, drug purity and dosage, method of ingestion, and the drug state (e.g., intoxication versus withdrawal). The E factors include the degree of social density, social expectations of drug effects, accessibility of potential victim(s), weapon accessibility, and violence-related social norms. As the unique elements within these three factors combine, they create one of seven potential effects on the risk of interpersonal violence. This article describes these seven potential relationships between substance use and violence and explores the clinical implications of each.

Independent Effect

In the first possible P+D+E=V interaction, we have an act of violence by an individual who has consumed a drug, but the drug plays neither a promoting nor inhibiting role in the violent act. The failure to recognize the potential for such an independent effect is captured in comments like, “More than 80 percent of persons who commit acts of violence do so under the influence of alcohol or another drug.” This statement implies that 80% of these acts were caused by drug impairment. Such pronouncements, by representing correlation as causation, make great propaganda but poor science and social policy.

There are also clinical implications that grow out of the failure to recognize these independent effects. If the addictions

professional assumes that a client's battering of his or her intimate partner or a mother's abuse of her child is a function of drug toxicity or radical personality change resulting from drug use, then the clinical corollary is that the violence will spontaneously remit with abstinence. But if the violence was unrelated to substance use, then the partner or the child could be at an even greater risk of victimization by a now sober and more physically competent perpetrator.

Clinical signs of violence as an independent behavior include violent acts that predated the onset of substance use, and a pattern of violence in which the timing, frequency and intensity of violent episodes are unrelated to drug choice, level of intoxication or stage of withdrawal. Where this is the case, violence needs to be understood as an independent, primary problem that requires concurrent treatment.

Rationalizing Effect

In this interaction, alcohol or other drug use plays no role in an act of violence but its real or feigned presence is used retrospectively to excuse aggressive behavior ("The devil/drug made me do it!") Substances may even be consciously used to provide a post-assault escape from personal responsibility. Substance use does contribute to violence in cultures that permit this escape from accountability, but its contribution must be understood in symbolic and social terms, not in terms of psychopharmacology.

Two clinical implications emerge from an understanding of this potential interaction between substance use and violence. The first is an awareness by the addictions professional that he or she may have clients feigning a substance disorder to escape culpability for violent criminal conduct that had little or nothing to do with substance impairment. This pattern of "pseudoaddiction" is indicated by the marked absence of denial and minimization of substance use (in fact, quite the opposite), and a history of conduct disorder predating drug experimentation. Such clients initially comply but later escalate boundary testing and aggression within the treatment milieu.

Causative Effect

A third potential interaction between a person, drug and environment involves situations in which violence is elicited by the effects of a drug with little contribution from the person or the environment. This raises the question: Can a drug cause an individual to commit an act of violence where there is no pre-existing risk for such aggression? The answer is a qualified yes, with a recognition that such instances are rare. This category of substance-influenced violence includes toxic organic psychoses resulting from acute or chronic drug use that are accompanied by delusions of persecution and auditory or visual hallucinations. In these states, drug-induced errors in perception and cognition can dramatically increase the risk of violence even in persons without a history of, or innate propensity for, aggression. Conditions that are traditionally included within this category include toxic organic psychoses produced by alcohol (e.g., idiosyncratic intoxication, alcoholic hallucinosis), stimulants such as cocaine and methamphetamine, and excessive doses of hallucinogens. The addictions professional, particularly those working in emergency services, intake or detoxification units, should be aware of the symptom configurations of the major toxic organic psychoses associated with violence. Most of these conditions require careful clinical management to simultaneously protect the safety of the client, the service professional, and the public.

Additive Effect

The fourth potential relationship between substance use and violence is a common one. Here we have a person who has some innate risk for violence (that includes most of us) but who under most circumstances is able to suppress violent impulses. A drug could play an inciting role in moving this individual across the threshold

of a violent impulse to a violent behavior. When we speak of additive effect, it means that substance use contributes to rather than causes violence. It makes this contribution by lowering the point of reactivity through disinhibition and impairment of judgment. In this case, substance intoxication doesn't create aggression; it simply lowers the threshold at which existing aggressive impulses are transformed into aggressive behavior.

The additive effect constitutes a significant portion of alcohol-related violence. This effect is particularly prominent when the following factors are combined: socioeconomic and psychological distress, high population density, high density of alcohol outlets, illicit and competing drug markets, and high density of handguns. Substances can generate a priming effect when an individual with high risk for aggression gets purposely "pumped" or "wired" to induce a chemical courage that intensifies the violent act.

One of the clinical implications of the additive effect involves the growing number of people being mandated to addiction treatment who do not meet traditional diagnostic criteria for addiction, but who will spend most of their lives in systems of punishment and control if they do not find a way to management this substance-violence interaction. Such individuals may be appropriately treated in addiction treatment programs if the program includes the following elements: special clinical tools to assess and treat individuals with a history of violent victimization and perpetration, personally relevant rationales for abstinence, and a wide menu of metaphors for the reconstruction of personal identity and interpersonal relationships. In an individual lacking the classic symptoms of alcoholism, the insight, "when I drink, I go to jail," may be more transformative than the mantra "I have the disease of alcoholism." Similarly, linking sobriety to the metaphors of "freedom" and "self-control" may be more meaningful for these clients than the metaphors of "powerlessness" and "surrender."

Synergistic Effect

In our fifth possible interaction between substance use and violence, persons who combine exceptionally high risks for and past histories of violent perpetration are combined with high risk drug choices, dosages and methods of ingestion. This usually creates a risk and level of violence far exceeding the additive effect. What is produced instead is a multiplication effect that increases the risk and intensity (potential lethality) of violence.

Studies of persons who have committed multiple acts of violence, committed acts of violence against multiple targets, and committed acts of violence in patterns of self-accelerating frequency and intensity reveal a profile of this worst possible drug-person-environment interaction. This risk profile, which has emerged from the pioneering research of Dr. Lonnie Athens (see his *The Creation of Dangerous Violent Criminals*,1992, and *Violent Criminal Acts and Actors Revisited*, 1997) and others, often includes the following developmental sequelae:

- Neurological trauma (e.g., prenatal drug exposure, birth complications, blunt trauma, malnutrition, infection/fever) as evidenced by a history of seizure disorders or cognitive/sensory impairments.
- Neurological adaptations (changes in epinephrine [adrenalin], noradrenaline, and serotonin levels) resulting from sustained stress/trauma and as evidenced by atypical physical/emotional reactivity to environmental stimuli, atypical pain tolerance, and use of drugs to achieve state regulation.
- Abandonment (the failure to bond/attach; absence of safety, consistency and continuity of care in a primary relationship; early loss of primary relationships; isolation and self-containment; emotional numbing; inability to trust) (See Ken Magid and Carole McKelvey's *High Risk: Children without Conscience*, 1989).

- Brutalization (physical, sexual, emotional victimization) accompanied by multiple traumagenic factors (early onset of abuse, long duration of abuse, multiple perpetrators, perpetrators drawn from the family/kinship network, boundary invasive forms of abuse; failure to protect following disclosure).
- Horrification (exposure to the violent victimization of others).
- Violent coaching (transmission of the technology of violence via violent mentors, paramilitary subcultures or mass media).
- Violent style (onset and increased frequency and intensity of violence).
- Virulence (rigid self-encapsulization, predatory view of all interactions, preoccupation with power and control, aggression a core element of identity, high risk of lethality).

There are many early symptom clusters that predict this risk profile (enuresis, fire-setting, cruelty to animals) as well as protective factors that can interrupt this developmental trajectory (e.g., healthy surrogate families, non-violent coaching, early professional treatment). When this developmental trajectory is not interrupted, we have an individual "wired" for violence via:

- bias for action (as opposed to cognitive or emotional processing),
- atypical tolerance for pain,
- propensity to attribute hostile intent to others and misinterpret harmless cues as threatening,
- limited impulse control and problem solving abilities,
- impaired abilities to bring emotion under control once released,
- inability to initiate or sustain intimate relationships, and
- diminished capacity for empathy and remorse.

Collectively, such characteristics create a high risk for violence apart from any drug-related influences. A synergistic effect occurs when drugs are consumed whose dose and frequency of use, method and duration of use, and pharmacological effect inflame this already high risk (See Illustration).

Most addiction professionals, unless cross-trained via advanced studies in psychiatry or psychology, are not qualified to treat such individuals by themselves, but may be appropriately included in multidisciplinary teams assembled for this purpose.

Neutralizing Effect

The fact that certain drugs might work to lower the risk of violent assault has long been known in medicine. In persons whose aggressive and violent behavior is related to a primary psychiatric disturbance, a broad spectrum of psychotropic medications are available to bring these symptoms under control, increase the quality of their lives, and reduce their threat to others. Pharmacological interventions are similarly utilized to chemically inhibit those with histories of repeated sexual assaults. A question remains about the extent to which illicit drug use can reduce violence within particular individuals. Drugs that lower one's threshold of sensory overload, lower anxiety, blunt emotional experience and lower psychomotor activity could produce such an effect.

In an individual who brings a high risk for violent assault, drugs could be ingested that could alter this degree of risk. Alcohol intoxication, for example, might elevate that risk (via disinhibition) while opiates and low-potency cannabis might inhibit violence. Someone with high risk for violence could exhibit no such behavior during periods of heroin intoxication, but might pose a great threat of violence during withdrawal or when drug free.

One clinical implication of this neutralizing effect can be seen in a client maintained on methadone who might pose little threat of violence while being

maintained, but whose threat could dramatically increase if the client were "administratively detoxed" due to rule infractions. The increased risk of violence should be a consideration in the clinical protocol governing such decisions. This does not imply that someone regularly using narcotics is incapable of committing an act of violence. It merely means that to do so, he or she must break through the narcotic shield that diminishes the likelihood of such action. In contrast, alcohol, at all but the highest doses, provides no such shield while lowering the reactivity threshold at which aggressive impulse turns into violent behavior. In a person at personal risk for violence, alcohol acts like gasoline on a fire. In the same person, narcotics are like taking fuel or oxygen from the fire.

Signs of this neutralizing effect include a pattern of violence that predates the onset of substance use, declines or disappears during periods of use, but reappears during periods of voluntary or imposed abstinence. Treatment alternatives under such circumstances include substituting a medically monitored licit substance for the less reliable illicit drug or, where possible, replacing the chemical shield against violence with a psychological shield.

Contextual Effect

To illustrate how the environment can influence the risk for violence, we will close this discussion with a brief review of how the E element of our formula can tip the scales toward violence. Contextual violence occurs when an act of violence emerges not from personal risk, pharmacology, or their interaction, but from a social environment in which violence is a learned way to achieve status and power and to resolve problems. This effect is most intense in the marriage between drug and criminal cultures. The 1980s witnessed a significant increase in the number of people entering treatment from such cultures who had been socialized to view violence as an appropriate strategy to maintain, protect, or expand one's territory within illegal drug markets. As that value spread, violence as both a strategic behavior and as a core dimension of personal character increased. The treatment of this pattern of violence focuses not on the drug but on removal of the individual from anti-social subcultures, the development of non-violent skills and values, and enmeshment of the individual in a pro-social culture of recovery.

The addictions professional faces many challenges in addressing the issue of violence. These challenges, which range from the clinical to the ethical and legal, all hinge on understanding the complex relationship between substance use and violence. This article has underscored the complexity of this relationship by describing seven potential interactions between individuals, psychoactive drugs, and the physical and social environments in which they are consumed.

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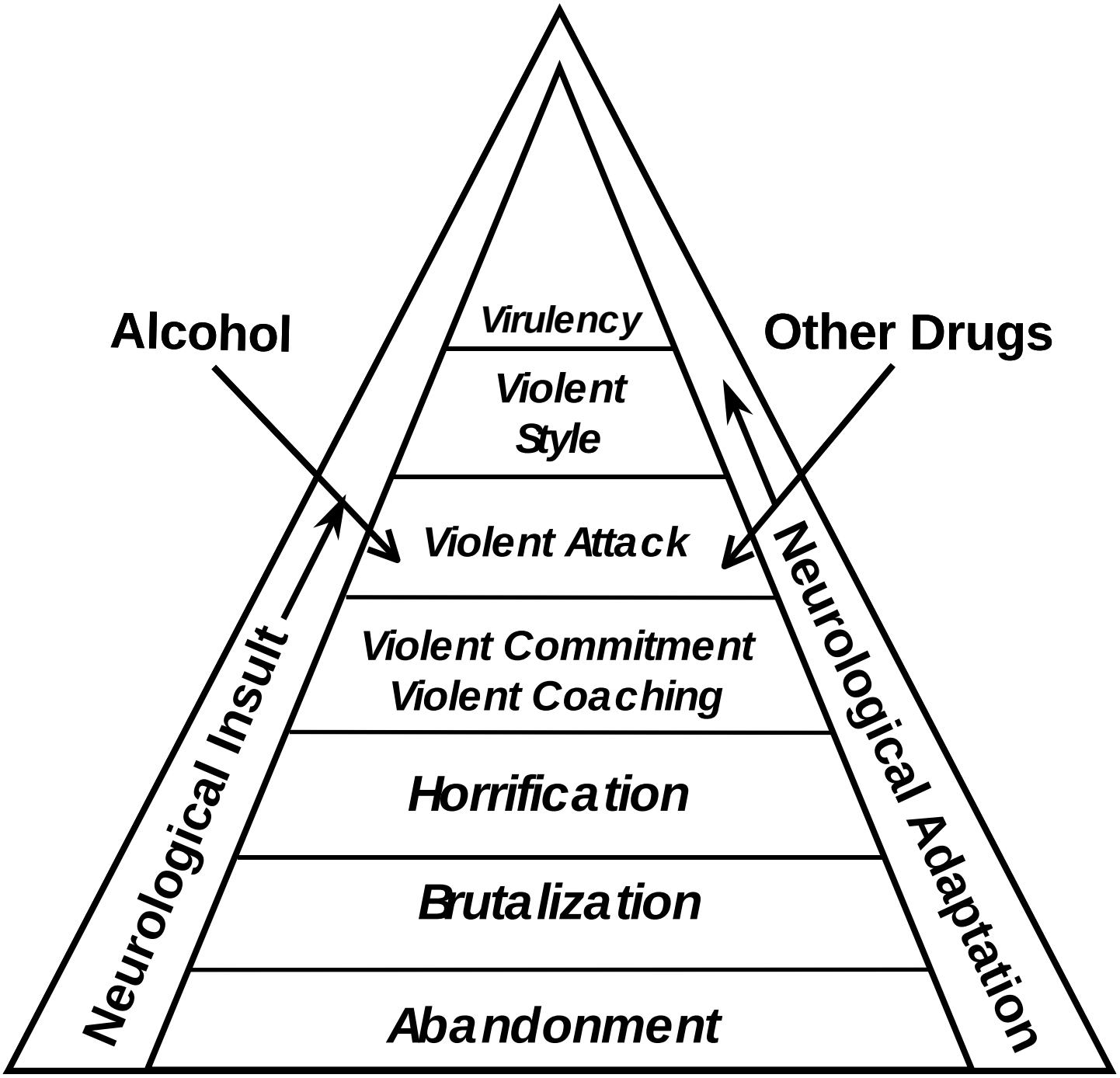

** This illustration is based on the work of Dr. L. Athens and incorporates additional work by K. Magid & C. McKelvey & W. White.*

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2004). Tales from a jag-house. *Recover Magazine*, 4(5), 24-26. Posted at **www.williamwhitepapers.com**

HISTORY CORNER
Tales from a Jag-House

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The affluent alcoholic has always had institutions that catered to his or her needs for periodic detoxification and physical and emotional renewal. When inebriate homes, inebriate asylums and addiction cure institutes collapsed in the opening decades of the 20th century, a new social institution quietly emerged on the American landscape. This new institution was the small, local "drying out" facility that offered discrete care for the affluent alcoholic. These sanatoria and rest homes became known as "dip shops" (a derivative of dipsomania--a medical term for the binge drinking pattern of alcoholism), "jitter-joints," "Jag-farms," or "jag-houses." Operating invisibly throughout the United States during the first half of the 20th century, their presence is revealed primarily via brief references in the autobiographies of American alcoholics. There is one published work, however, that provides a clearer window into the inner operations of the early 20th century jag-house.

In 1909, a most unusual book was published. Authored by C. and J.A. Jones, the book was entitled, *Opisthophorus: Or, The Man Who Walked Backwards*. The purpose of the book was to better understand "the sufferings and temptations of a drunkard" as well as the "possibilities of his redemption." It pursues this goal by describing the experiences of "men of fine capabilities who when sober, are often the most refined of gentlemen" during their stay in a jag-house. Jones' book provides a unique portrayal of the workings of one such institution.

Two physicians are at the center of Jones' tale: a Dr. Coin who is personally transported by a friendly judge to Ohio where the doctor is to be treated for his alcoholism by a Dr. Car. The jag-house to which Dr. Coin is taken is a large home encircled with shade trees within which a handful of men are in varying stages of recovery from alcoholism. The house itself consists of private bedrooms on the second floor with a clubhouse, library and kitchen on the first floor. The home is administered by a middle-age couple and an old-maid who served as a cook and who believed that most of the patients were "drunken fools and not worth the powder and shot it would take to kill

them." The medical and psychological care of the residents was provided by Dr. Car, who made twice-daily visits to all the patients. The care consisted primarily of tapered withdrawal via decreasing doses of whiskey, hypodermic injections of undisclosed (but sedating) content, regular ingestion of medicinal tonics, nourishing food, sober fellowship, and the motivational talks of Dr. Car.

The social attitudes toward alcoholism at the time are revealed in a letter Dr. Coin receives from his father-in-law. The letter castigates Dr. Coin for putting his faith in a quack doctor, admonishes him to be a man and control his drinking, and warns him to not attempt reconciliation with his wife.

Following many weeks of treatment, Dr. Coin and his fellow patients are given a certificate of graduation, admonished to remain forever abstinent from all forms of alcohol, and invited to return each year for a reunion of all the former patients and their families. The book ends with Dr. Coins' joyous reunification with his family and his resolution to never touch alcohol again.

Dr. Coins tale was replicated by the thousands in small homes and sanatoria across the country where well-to-do alcoholics sought help outside of the hospitals that would not admit them in these years. The Jones' text illuminates the jag-house as a little-known milestone in the American treatment of alcoholism.

But one mystery remains: What's with this strange title? Jones explains that OPISTHOPHORUS is an alcoholic disease characterized by the inability to walk forward. Jones explains: "When the one so afflicted is told to advance, he may use every effort to do so, but can only succeed in going backward. He sees his shopmates and old acquaintances getting on comfortably, but the poor fellow who is taken with Opisthophoria can never keep up with them." So the next time someone asks you if you are recovering, you can proudly declare your status as a recovering Opisthophoric.



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Citation: White, W. (2004). Teaching addiction/treatment/recovery history: Rationale, methods and resources. Journal of Teaching in the Addictions, 2(2):33-43. Posted at **www.williamwhitepapers.com**

Teaching Addiction/Treatment/Recovery History: Rationale, Methods and Resources

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Abstract

History can be an empowering tool in the education of those working in addiction-related occupations. This article explores the importance of the historical perspective in addiction studies, outlines principles to guide the presentation of historical data, and reviews some of the best resources that can be used to present historical material in a comprehensive, objective, and engaging manner.



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Citation: White, W. (2004). Toward a recovery lexicon. Posted at **www.williamwhitepapers.com**

Toward A Recovery Lexicon
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The term r*ecovery*, as used in the addictions field, is the sustained process through which severe and persistent alcohol and other drug (AOD) problems (meeting DSM-IV criteria for substance abuse or dependence) are resolved (no longer meeting DSM-IV criteria for substance abuse or dependence). In contrast to treatment interventions that focus on professional intervention technologies, recovery is about the needs, experiences and achievements of the individual/family seeking to resolve AOD problems.

The term *family recovery* conveys the processes through which family members impacted by severe and persistent AOD problems individually and collectively regain their health. Family recovery has three dimensions: 1) the healing of individual family members, 2) the healing of family subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships), 3) healing the family as a system, repairing family structure; redefining family roles, rule and rituals; and achieving recovery-conducive boundary transactions with people and institutions outside the family.

Like other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of *full recovery* (complete and enduring cessation of all AOD-related problems) or a state of *partial recovery*. Partial recovery conveys two different conditions: 1) the failure to achieve full recovery as just defined, but the achievement of a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems, or 2) the achievement of complete abstinence or stable moderation but the failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery can constitute a stage preceding full recovery, constitute a permanent state, or constitute a hiatus in AOD problems with eventual reversion to their former level.

Persons who achieve full, uninterrupted recovery for five years, like persons who have achieved similar patterns of symptom remission from other primary

health disorders, can be described as *recovered*. Those who achieve full symptom remission for less than five years or have achieved partial recovery (marked reduction of but some residual symptoms) can best be described as *in recovery* or *recovering*. While use of the latter term in later year (after five years) of recovery reminds the individual that recovery is an enduring process requiring sustained vigilance and recovery maintenance, such use of the term *recovering*, by inadvertently conveying to the public that there is no permanent solution for severe and persistent AOD problems, contributes to the stigma and pessimism attached to these problems.

Styles of recovery and *pathways of recovery* are phrases that reflect the varieties of ways people successfully approach the resolution of AOD problems. It is a recognition that (in the words of AA co-founder Bill Wilson), "The roads to recovery are many" (Wilson, 1944). *Cultural pathways of recovery* are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. Across varied cultural contexts, such pathways might be developmental (e.g., something to be resolved through maturation and marriage), medical (e.g., response to an alcohol-related health problem), religious (e.g., conversion and/or affiliation with an abstinence-based faith community), or political (e.g., rejection of alcohol as a "tool of genocide").

The most critical variation involves differences in how one's relationship with psychoactive drugs has changed. The scientific literature on the resolution of AOD problems documents three such variations 1) *abstinence-based recovery* (complete abstinence from alcohol and other drugs) 2) *moderation-based recovery* (the deceleration of AOD use to a subclinical[1] level that no longer generates harm to the individual or society), and *medication-assisted recovery* (the use of medically-monitored, pharmacological adjuncts to support recovery from addiction e.g., detoxification agents, stabilizing agents, aversive agents, antagonizing agents, anti-craving agents or psychoactive drugs prescribed for the treatment of co-occurring physical or psychiatric disorders. Abstinence-based and medication-assisted styles of recovery predominate in patterns of severe alcohol and drug dependence, whereas moderation-based styles of recovery predominate in patterns of less severe and enduring alcohol and other drug problems.

The concept of moderation-based recovery is linked to the understanding that alcohol and other drug problems exist on a wide continuum of severity and vary in their patterns of acceleration and deceleration. The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood. Most of these individuals do not go on to develop enduring substance-related problems, but instead quickly or gradually moderate their substance use through the progressive assumption of adult responsibilities (Fillmore, et al, 1988).

Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting that moderation was an option for some problem drinkers, but not "alcoholics" like themselves. The following two excerpts reflect their beliefs and attitudes about moderation-based recovery.

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason—ill health, falling in love, change of environment, or the warning of a doctor—becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention*

[1] No longer meeting DSM-IV criteria for abuse or dependence.

(*Alcoholics Anonymous*, p. 31, first edition).

If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people! (*Alcoholics Anonymous,* p. 42, first edition).

Recovery can occur at different stages of problem development and progression. There are patterns of *high bottom recovery* **(**the initiation of recovery through a breakthrough of awareness of losses that could accrue from continued alcohol and other drug use) among people who have not yet suffered such losses, and there are patterns of *low bottom recovery* in which recovery is achieved by individuals in the latest stages of addiction who have experienced great losses and anguish related to their drinking and drug use.

Variations in recovery styles are influenced by the degree of problem severity and by one's *recovery capital*. *Recovery Capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-disordering condition (Granfield and Cloud, 1999).

Recovery styles vary by their pattern of onset and course. Recovery can result from a process of sudden, *transformational change* (Miller and C'de Baca, 2001) or result from a process of *incremental change* marked by predictable stages of recovery (Prochaska, et al., 1992). Long-term, permanent recovery from severe and persistent AOD problems often involves four broad stages of change: 1) *recovery priming* (experiences that open a doorway of entry into recovery), 2) *recovery initiation* (discovering a workable strategy of problem stabilization), 3) *recovery maintenance* (achieving recovery stability and sustaining and refining broader strategies of problem resolution with a continued life-focus on the recovery process), and 4) *recovery termination* (achievement of global health with diminished preoccupation with recovery). These latter periods have have also been referred to as *Stage II Recovery* ("rebuilding the life that was saved in Stage I") (Larsen, 1985, p. 15). Stage two recovery transcends the early concern with the addictive behavior and instead focuses on a reconstruction of personal character, identity, beliefs and interpersonal relationships. This stage has also been referred to as *complete recovery*--an "advanced state" of recovery marked by global health, a heightened capacity for intimacy, serenity and self-acceptance (Picucci, 2002).

Recovery styles vary by the degree and nature of resources within and outside the self that are used to initiate and sustain recovery. There are patterns of *natural recovery* (*solo recovery*)—the initiation and maintenance of recovery from addiction without involvement in professionally-directed treatment or recovery mutual aid societies. This type of resolution of AOD problems has gone by many names in the scientific literature: "maturing out" (Winick, 1962, 1964); "autoremission" (Vaillant, 1983; Klingeman, 1992); "self-initiated change" (Biernacki, 1986); "unassisted change" (McMurran, 1994); "spontaneous remission" (Anthony and Helzer, 1991); "de-addiction" (Klingeman, 1991); "self-change" (Sobell, Sobell, Toneatto, and Leo, 1993); "natural recovery" (Havassey, Hall and Wasserman, 1991); "self-managed change" (Copeland, 1998) and "quantum change" (Miller and C'de Baca, 2001). There are also patterns of *affiliated (or assisted) recovery* in which the initiation and maintenance of recovery is achieved through relationships with other individuals in recovery, and patterns of *disengaged recovery* in which the initiation of recovery through professionally-directed treatment and/or mutual aid participation is followed by the subsequent maintenance of that recovery without significant participation in addiction recovery mutual aid groups. A relatively recent phenomenon is the advent of *virtual recovery*—the achievement or maintenance of recovery through Internet support groups, with little or no participation in face-to-face support meetings.

Recovery styles also reflect different

recovery identity patterns—variations in the extent to which AOD problems and the recovery process influence one's identity, and the degree to which one relates to other people who share this recovery process. There are those with recovery-neutral identities (persons who have resolved severe AOD problems but who do not self-identify themselves as "alcoholics" or "addicts" or "persons in recovery") and those with recovery-positive identities (those for whom the status of recovery from addiction has become an important part of their personal identities). There are *acultural styles of recovery* in which in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery and without identification with a larger *recovery community* or *culture of recovery* (a social network of recovering people with their own history, language, rituals, symbols, literature, and values that collectively nurture and support long-term recovery from AOD problems). There are *bicultural styles of recovery* in which individuals sustain their recovery through simultaneous involvement in the culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). There are *enmeshed styles of recovery* in which one initiates and maintains recovery in almost complete sequestration within the culture of recovery. Communities of recovery is a phrase coined by Ernest Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a reciprocity of "fit." The growth of these divergent communities reflects the growing varieties of recovery experience (Kurtz, 1999). Style differences based on the evolution in how one relates, or does not relate, to these communities of recovery might is part of what could be described as one's *recovery career*. The concept of "career" has been used to describe the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, et al., 1997). Recovery career is an extension of this application and refers to the evolving stages in one's identity, one's relationships with others, and, in some cases, styles of involvement with mutual aid groups.

There are considerable differences in recovery styles based on the presence or absence of religion and spirituality as an important dimension of the recovery process. There are patterns of *faith-based recovery* (the resolution of severe alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and within the mutual support of a faith community) and patterns of *secular recovery*--a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or religious rituals (prayer).

Because severe and persistent AOD problems impact many areas of life functioning, recovery from such problems must be measured across multiple dimensions. These *zones (or domains) of recovery* include alterations in 1) AOD consumption (measurable changes in presence, frequency, quantity, intensity [risks to self and others], and duration of primary and secondary drug use) 2) AOD-related consequences, 3) physical health, 4) psychological/emotional/spiritual health, 5) family/relational health, and 6) lifestyle health e.g., developmentally appropriate, pro-social and (White, 1996).

The shift from defining recovery solely in terms of what is deleted from one's life (alcohol or other drugs) to what is added to one's life (global health) is reflected in such terms as *emotional sobriety*--a phrase coined by A.A. co-founder Bill Wilson (1958) to describe a state of emotional health that far exceeded simply the achievement of not drinking. Wilson defined emotional sobriety as "real maturity . . . in our relations with ourselves, with our fellows and with God." It is also reflected in the word *Wellbriety—a* term used in Indian Country to depict recovery as more than just symptom suppression. Wellbriety implies the pursuit or achievement of global (physical, emotional, intellectual, relational, and spiritual) health, or "whole health" (Coyhis, 1999; *Red Road*

to Wellbriety, 2002). It is marked by the emergence of such *recovery values* as honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000). The development of stable recovery and global health across recovery pathways tend to be marked by the presence of daily *recovery rituals*: 1) centering rituals, 2) mirroring rituals, 3) acts of self-care, and 4) unpaid acts of service (White, 1996).

Some individuals are involved in concurrent or sequential recovery processes from two or more conditions or experiences. The overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders is sometimes referred to as *serial recovery*.

Persons with severe and prolonged AOD problems fare poorly in systems of care organized to provide acute intervention (detoxification and brief psychosocial stabilization). There are growing calls to shift the focus of addiction treatment from acute intervention toward models of sustained *recovery management*. Recovery management models wrap traditional treatment in a continuum of professional and peer-based pre-recovery, recovery initiation and recovery maintenance support services, with a particular focus on post-treatment monitoring (recovery check-ups)(Dennis, Scott, & Funk, 2003), stage-appropriate recovery education, assertive linkage to communities of recovery, recovery community resource development and, when needed, early re-intervention. *Peer-based recovery support services* are services designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life in recovery. Recovery management models shift traditional intervention models from a focus on treatment planning to a focus on *recovery planning* (Borkman, 1997).

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Citation: White, W. (2005). Treatment Works: Is it time for a new slogan? *Addiction Professional*, 3(1), 22-27. Posted at **www.williamwhitepapers.com**

Treatment Works! Is it time for a new slogan?

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Catchy slogans that convey complex ideas and sentiments have a rich history within the alcohol and other drug (AOD) problems arena. They have been used to:

- promote drug use ("I'd walk a mile for a…; "Tune in, turn on, drop out.")
- discourage drug use ("Just Say No"; "This is your brain; …."),
- depict the nature and source of AOD problems ("Alcoholism is a disease"; "Capitalism plus dope equals genocide")
- portray the character of those experiencing AOD problems ("The alcoholic is a sick person"; "Users are losers")
- promote particular AOD-related social policies ("Zero tolerance"; "Treatment works")
- shape recovery-supportive self-talk ("One day at a time"; "First things first").

Institutions whose missions are related to AOD consumption and its related problems have all coined slogans to promote their ideological, financial and therapeutic interests. Such slogans can operate at multiple levels (personal, family, professional, institutional and cultural), work at some levels while failing at others, and work in the short term but fail over time.

Rethinking "Treatment Works"

The slogan *Treatment Works* is currently the central promotional mantra of the addiction treatment industry. The slogan has many desirable attributes. It is compact and catchy. It celebrates the hundreds of thousands of people who have achieved recovery from substance use disorders through the vehicle of professional treatment. It honors the commitment and competence of those who work on the front lines of addiction treatment. Historically, the slogan affirms the superiority of addiction treatment institutions over the "drunk tanks" (of city jails), "foul wards" (of city hospitals) and "back wards" (of aging state psychiatric hospitals) that preceded them. Culturally, the slogan counters highly publicized accounts of celebrity relapse following treatment and rebuts attacks on the legitimacy of addiction treatment and its conceptual foundations.

Scientifically, *Treatment Works* proclaims the positive findings of addiction treatment outcome research. With such apparent advantages, it is little wonder that the slogan has achieved wide dissemination. The problem is that slogans and sloganeering are complex entities and processes plagued with unintended consequences. This article, written by a long-time promoter and defender of addiction treatment, argues that the slogan *Treatment Works* is ill conceived and should be replaced.

The slogan *Treatment Works* erroneously conveys the existence of a singular, static entity—*treatment*--that is consistent in character and quality across the United States. The reality is quite different. Addiction treatment is a smorgasbord of diverse settings, philosophies, and techniques that vary significantly in their effectiveness (Wilbourne & Miller, 2003). There are widely utilized methods of addiction treatment that lack scientific support (Miller & Hester, 1986), and methods of treatment supported by substantial scientific evidence that continue to be publicly and professional stigmatized (Kreek & Vocci, 2002). Outcomes of addiction treatment vary by client and program characteristics (Miller, Walters, & Bennett, 2001; Wilbourne & Miller, 2003), vary across different addiction counselors (McLellan, Woody, Luborsky, & Goehl, 1988) and can vary over time due to the instability of treatment organizations and the high turnover of the addiction treatment workforce (McLellan, Carise, & Kleber, 2003; Roman, Blum, Johnson, & Neal, 2002). The sweeping generalization *Treatment Works,* by ignoring such variability and instability, fails to enhance the public's ability to make informed choices about addiction treatment services.

The slogan *Treatment Works* conveys a single pathway model of AOD problem resolution and perpetuates an acute care model of intervention that for many people does not "work." The slogan *Treatment Works* fails to acknowledge the resolution of AOD problems without professional treatment, and ignores the role of self, family, friends, and other indigenous recovery supports in the recovery process. The slogan implies that persons with substance use disorders are "broken" but can be "fixed" via a single, brief episode of professional intervention. This acute model of intervention is ill suited for individuals with high personal vulnerability for AOD problems, high problem severity and chronicity, multiple co-occurring problems, and few intrapersonal and interpersonal resources to support recovery initiation and maintenance (McLellan, O'Brien, Lewis & Kleber, 2000; White, Boyle, & Loveland, 2003). The effusive optimism of the *Treatment Works* slogan masks a brutal reality: there are legions of families whose loved ones are dying addiction-related deaths, languishing in prisons, or living addiction-deformed lives—all after one or more episodes of addiction treatment. The slogan *Treatment Works* is painfully contradicted by the experiences of these families.

The slogan *Treatment Works* misrepresents the highly variable outcomes of addiction treatment. Research findings challenge the mechanistic view of treatment reflected in the slogan *Treatment Works.* The slogan fails to convey the following limitations of addiction treatment as currently practiced in the United States.

Failure to Attract/Limited Access
Only 10% of persons in need of treatment for a substance use disorder receive such treatment in any given year (Substance Abuse and Mental Health Services Administration, 2003). Access to treatment in many communities is compromised by an absence of treatment resources, waiting lists for such services, and high rates of waiting list dropout (Little Hoover Commission, 2003; Hser, Maglione, Polinsky, & Anglin,

1998; Donovan, Rosengren, Downey, Cox, & Sloan, 2001).

Treatment Attrition More than half of clients admitted to addiction treatment do not successfully complete treatment (24% leave against staff advice; 18% are administratively discharged for various infractions; 9% are transferred) (SAMHSA, 2002).

Inadequate Treatment Dose Of those who successfully complete addiction treatment, many receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse (National Institute on Drug Abuse, 1999; SAMHSA, 2002).

Absence of Continuing Care Post-discharge continuing care can enhance recovery outcomes (Johnson & Herringer, 1993; Godley, Godley, & Dennis, 2001; Dennis, Scott, & Funk, 2003), but only 1 in 5 clients actually receives such care (McKay, 2001).

Post-treatment Relapse & Readmission Of those admitted to addiction treatment, 60% already have one or more prior treatment admissions (24% have three or more prior admissions) (Substance Abuse and Mental Health Services Administration, 2001). The majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2003), 80% of whom resume use within 90 days of discharge (Hubbard, Flynn, Craddock, & Fletcher, 2001). Between 25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year, 50% within 2-5 years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989; Simpson, Joe, & Broome, 2002). Most persons professionally treated for substance dependence who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Hristova, 2002).

Instability of Early Recovery Durability of recovery from alcoholism (the point at which risk of future lifetime relapse drops below 15%) is not reached until 4-5 years of sustained remission (De Soto, O'Donnel, & De Soto, 1989; Jin, Rourke, Patterson, Taylor, & Grant, 1998). Long-term studies of individuals treated for narcotic addiction reveal that 20-25% of those who achieve five or more years of sustained abstinence later return to opiate use (Simpson & Marsh, 1986; Hser, Hoffman, Grella, & Anglin, 2001).

Post-treatment Mortality Long-term follow-up studies of clients treated for addiction reveal a high mortality rate related to accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide and homicide (Hser, et al., 2001).

These stark findings do not mean that addiction treatment has no value. Treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third, substance use decreases by an average of 87% following treatment, and substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). Recent studies confirm that addiction treatment outcomes are comparable to treatment outcomes for other chronic health conditions (e.g., type I diabetes, hypertension and asthma) (McLellan, O'Brien, Lewis, & Kleber, 2000), but those who cite this finding (as an elaboration of the *Treatment Works* slogan) delude the public and policy makers if they fail to also report that the annual relapse rates for these other conditions range from 30-70% (McLellan, et al., 2000).

The National Institute on Drug Abuse's *Principles of Addiction Treatment* provides a more scientifically grounded portrayal of addiction treatment outcomes.

These principles, from which alternative slogans for public consumption could be generated, emphasize that no single treatment for addiction is effective for all individuals and that recovery from addiction can take a long time and span multiple treatment episodes (NIDA, 1999). Many people achieve sustained addiction recovery with the assistance of professional treatment, but the limitations of treatment are not adequately conveyed by the slogan *Treatment Works.*

The slogan *Treatment Works* shifts the responsibility for recovery from the person being treated to the treatment professional, but blames the client when treatment does not result in sustained abstinence. For addiction treatment consumers, the slogan *Treatment Works* conveys that recovery is something done to them rather than achieved by them. But paradoxically, the slogan provides an escape from accountability for treatment providers. If *Treatment Works* is an a priori assumption, any continuing problems following treatment are the fault of the client, not the intervention design or the intervener. The slogan *Treatment Works* creates situations in which individuals can be subjected to flawed interventions (interventions whose nature, intensity and duration offer little likelihood of sustained, stable recovery) and then punishes these clients (e.g., lost employment, violation of probation and incarceration, lost custody of children) on the grounds that "they had their chance." This same logic contributes to the elevated expectations and dashed hopes through which intimate partners, family members and friends prematurely abandon those with severe AOD problems.

When the nineteenth-century inebriate homes/asylums and addiction cure institutes oversold what their interventions could achieve (advertising claims of 95-100% cure rates), it was only a matter of time before most citizens personally knew someone who relapsed following treatment. Rising cultural pessimism about the prospects of addiction recovery contributed to the collapse of America's first treatment institutions and the systematic transfer of those with AOD problems to systems of punishment and control (White, 1998). The addictions field risks replicating this history by brandishing a slogan that serves its institutional interests in the short run, but which could wound the field and those it serves in the long run.

Alternative Slogans

The purpose of this commentary is not to offer a specific alternative to the slogan *Treatment Works,* but a few closing reflections on the nature of such alternatives is warranted. The phenomena of addiction and recovery are much too complex to be represented in a single slogan and are best portrayed through a cluster of interrelated messages. Ideally, these messages should:

- be recovery-focused , e.g., Recovery is everywhere (http://www.recoveryiseverywhere.com).
- communicate hope, e.g., Addition recovery: We're living proof!
- emphasize the role of personal choices, responsibilities and enduring efforts inherent in the recovery process, e.g., Addiction recovery is voluntary. Volunteer today! / Recovering from addiction is tough; Keep quitting until you quit forever.
- affirm the varieties of recovery experience, e.g., There are many pathways to recovery. Find the right one for you. / "The roads to recovery are many" (Wilson, 1944).
- extol the role of family and community in the recovery process, e.g., Addiction affects the whole family. The good news is that recovery does too. / Recovery is contagious: Find people who have it.
- detail the potential role of treatment in recovery, e.g., Addiction recovery is possible; professional treatment can help
- create informed consumers, e.g., All addiction treatment is not the same. Choose wisely.
- incorporate a wide menu of metaphors to initiate and anchor recovery, e.g., Addiction is racial suicide; Resist,

Recover, Rebuild! “Your body is the temple of God; is it time you stopped poisoning it?

- call recovered and recovering to join the “wounded healer” tradition, e.g., You’re living proof that addiction recovery is possible: Isn’t it time you told others?

Summary

Treatment Works, the central promotional slogan of the addiction treatment industry, misrepresents the nature of addiction treatment and its probable outcomes and misplaces the responsibility for such outcomes. The slogan should be abandoned and replaced by a cluster of messages that shift the emphasis from the intervention (treatment) to the desired outcome (recovery), extol the importance of personal choice and responsibility in the recovery process, portray the variable outcomes of addiction treatment, celebrate multiple pathways of recovery, affirm the roles of family and community support in addiction recovery, invite participation in professional treatment and recovery support services, and incorporate catalytic metaphors drawn from diverse medical, religious, spiritual, political and cultural traditions.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2004). Women who made (and are making) a difference. *Counselor*, 5(5), 25-29. Posted at **www.williamwhitepapers.com**

Women Who Made (and are Making) a Difference

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When I entered the field of addiction treatment in the 1960s, it was a man's world, and it had been a man's world for more than 175 years. It was a professional arena dominated by male service consumers, male service providers, male administrators, and male policy makers. Women filling such roles were an anomaly, not the norm. That world changed because women pioneers made significant contributions to the history of the addiction treatment field. The purpose of this article is to honor a few of these pioneers who made, and are making, a difference through their research, clinical innovation, public and professional education, public policy advocacy and through their philanthropy. Here are more than sixty women who made and are making a difference in the addiction treatment and recovery arena.

Dr. Andrea Barthwell has served as the Deputy Director of Demand Reduction in the White House Office of National Drug Control Policy. Before assuming this position, she served as medical director of several addiction treatment programs and as president of the board of the American Society of Addiction Medicine. Dr. Barthwell is a passionate and articulate advocate for enhanced accessibility and quality of addiction treatment.

Dr. LeClair Bissell is one of the modern pioneers of addiction medicine and the broader field of addiction treatment. Her contributions to the field are reflected in awards from the American Society on Addiction Medicine and the Christopher D. Smithers Foundation. Her publications include *Alcoholism in the Professions* (1985) and *Ethics for Addiction Professionals* (1987).

Claudia Black, PhD, has for more than two decades given voice to the impact of alcoholism on children and the family. She is the author of numerous books, including *It will Never Happen to Me* (1982).

Dr. Sheila Blume is an addiction psychiatrist and long-time advocate for the special needs of addicted women. She served as Director of the New York State Division of Alcoholism and Alcohol Abuse and Director of South Oaks Hospital in Amityville, NY and published more than 100 scientific articles on addiction.

Stephanie Brown, PhD, is the director of the Addictions Institute in Menlo Park, CA. and is the author of *Treating the*

Alcoholic (1985) and *Treating Adult Children of Alcoholics* (1988) and the co-author of *The Alcoholic Family in Recovery* (1999). Her pioneering work is helping illuminate the stages of personal and family recovery.

Barbara Cimaglio, **Christina Dye**, **Fran Harding**, and **Janet Zwick** are among the more than 20 women who currently direct state departments / offices / commissions responsible for the planning, funding and evaluation of addiction treatment services.

Stephanie Covington, PhD, is a widely acknowledged expert on addiction and recovery among women. She has served as the chair of the Women's Committee of the International Council on Alcoholism and Addiction and has published numerous articles and books, including *A Woman's Way Through the 12-Steps* (1994).

Geraldine ("Gerry") O. Delaney served for years as the Director of Alina Lodge in Blairstown, NJ. To her "students" who had failed to find recovery in other programs, she was known for the toughest of love. One of most charismatic and true characters of the addictions field, her letters were often signed, "G.O.D."

Jan DuPlain was an early public policy advocate for the needs of addicted women. She led the first Office of Women within the National Council on Alcoholism under the banner "Alcoholism is a Women's Issue."

Mathea Falco, Esq., served as Assistant Secretary of State for International Narcotics Matters under President Jimmy Carter. She is currently president of Drug Strategies, a national drug policy center and is a frequent contributor to *Counselor*.

Florence R. was the first female member of Alcoholics Anonymous. Her story appeared in the first edition of the book, *Alcoholics Anonymous* (1939), a title selected after she objected to the proposed title, "One Hundred Men."

First Lady Betty Ford courageously declared to the American public that she had been treated for, and was recovering from, addiction to alcohol and other drugs. She is the driving force behind the Betty Ford Center—a facility that has treated more than 64,000 individuals and adult family members since opening in 1982. Her powerful personal testimony continues to inspire the recoveries of women across the country.

Dr. Ruth Fox was a psychoanalyst who began specializing in the treatment of alcoholism in 1941. She went on to a distinguished career in the alcoholism field, including serving as the Medical Director of the National Council on Alcoholism from 1958 to 1969. In 1954, she founded the New York City Medical Society on Alcoholism—the precursor to the American Society of Addiction Medicine. Her written works include *Alcoholism, Its Scope, Cause, and Treatment* (1955).

Dr. Vernelle Fox was the pioneering force behind the Georgian Clinic and Rehabilitation Center for Alcoholics that opened in the early 1950s (in Atlanta and Savannah). She served as the Center's medical director from 1955 to 1970 and made significant national contributions within the re-emerging field of addiction medicine.

Wanda Frog has been a recovery advocate for Native American women and women of color for nearly forty years. Her contributions include the leadership she brought to the National Indian Board on Alcohol and Drug Abuse (NIBADA) and the National Association of Native American Children of Alcoholics (NANACOA).

Edith Gomberg, PhD, is Professor in the Alcohol Research Center, Department of Psychiatry, University of Michigan, where for more than 20 years she has conducted pioneering research on addiction in women and older adults.

Sarah Graham-Mulhall served as Deputy Commissioner of the State of New York Department of Narcotic Drug Control. She was a visible spokesperson and prolific writer on new patterns of opiate addiction and their treatment in the early twentieth century. Her published works included, *Opium: The Demon Flower* (1926).

Beverly Haberle (Executive Director of The Bucks County Council on Alcohol and Drug Dependence and Project Coordinator

of Pro-ACT--Pennsylvania Recovery Organization), **Lisa Mojer-Torres,** Esq., (civil rights attorney), and **Jeannie Villarreal** (Project Coordinator of Recovering Advocates for Treatment, Vallejo, CA) are part of a new generation of effective recovery advocates. They are included here to honor the women who are leading and working within grassroots recovery advocacy organizations across the country.

Dr. Lucy Hall served as Physician in Charge of the Reformatory Prison in Sherburne, Massachusetts. Her 1880 studies of female inebriates were the first studies to note the existence of domestic violence in the lives of addicted women.

Maya Hennessey is a long-tenured advocate on women's issues within the addictions field. She is included here to celebrate the contributions and struggles of those women who have served as advocates for women's issues within the addictions field.

Mary Hannah Hunt headed the Department of Scientific Temperance Instruction of the Woman's Christian Temperance Union. Under her leadership, the WCTU championed mandatory temperance education in the schools and minimum drinking age laws.

Joan Jackson, PhD, conducted pioneering studies in the 1950s and 1960s on the impact of alcoholism upon the family. Her work challenged pejorative characterizations of the wives of alcoholics and charted family adaptations to the progression of alcoholism.

Mary Beth Johnson, **Lonnetta Albright**, and **Nancy Roget** are among the women who have assumed leadership roles within the national network of addiction technology transfer centers. Their inclusion honors the growing number of women who are assuming administrative leadership roles within the field.

Charlotte Kasl, PhD, developed the 16-step empowerment model for women in recovery from addiction. She is the author of *Women, Sex and Addiction* (1990) and *Many Roads, One Journey* (1992).

Jean Kirkpatrick, PhD, founded Women for Sobriety in 1975—the first addiction recovery mutual aid society designed specifically for women. Her writings—including *Turnabout: Help for a New Life* (1978) and *Goodbye Hangovers, Hello Life* (1986)—and speeches helped lay the groundwork for the growth of gender-specific addiction treatment in the United States.

Joan Kroc began her philanthropy within the alcoholism field in 1976 with her financial sponsorship of Operation Cork, an alcoholism education program. She provided seed money for alcoholism-related projects for more than 25 years.

Candy Lightner organized Mothers Against Drunk Driving following the death of her 13-year-old daughter in 1980. MADD helped reshape America's attitudes and public policies toward impaired driving and forged the climate in which persons arrested for impaired driving are subjected to mandatory clinical screening.

Lois W. and Anne B. set up a service office in 1951 to support the growing number of family groups that were meeting in conjunction with Alcoholics Anonymous. In 1954, the office was incorporated as Al-Anon Family Group Headquarters, Inc. Fifty years later, there were more than 32,000 registered Al-Anon meetings in twelve countries.

Marty Mann, the first women to achieve prolonged sobriety within Alcoholics Anonymous, founded the National Committee for Education on Alcoholism in 1944. Her writings and speeches almost single-handedly laid the groundwork for modern alcoholism education and alcoholism treatment. Her books included *Primer on Alcoholism* (1950) and *Marty Mann Answers your Questions about Alcohol and Alcoholism* (1970). After decades serving as a public policy advocate, she worked as an alcoholism counselor at Silver Hill Hospital in New Canaan, Connecticut.

Mercedes McCambridge, famed Academy Award winning actress and alcoholism recovery advocate, testified

before Senator Harold Hughes' congressional subcommittee in 1969 in support of the legislation that provided the fiscal infrastructure for modern addiction treatment. She was one of the prominent figures who publicly declared their recovery from alcoholism in the National Council of Alcoholism's 1976 anti-stigma campaign, Operation Understanding. The story of her recovery from alcoholism is detailed in her 1981 autobiography, *The Quality of Mercy.*

Gail Milgram, EdD, is a Professor at the Rutgers Center for Alcohol Studies, Director of the School of Alcohol and Drug Studies, and co-director of the International Schools of Alcohol and Drug Studies. Her special interests include strategies to address alcohol-related problems on college campuses.

Stacia Murphy is one of the nation's leading recovery advocates. She served as the Director of the Alcoholism Council of New York and currently is President of the National Council on Alcoholism and Drug Dependence. She is helping NCADD affiliates across the country recapture their public education and public policy advocacy roots.

Dr. Marie Nyswander collaborated with Dr. Vincent Dole in the development of methadone maintenance treatment in the mid-1960s. Her published works included, *The Drug Addict as Patient* (1956). Her legacy continues through the work of one of her early collaborators, **Dr. Mary Jeanne Kreek**, professor at the Rockefeller University Laboratory on the Biology of Addictive Diseases.

Penny Page is currently responsible for the Rutgers Center of Alcohol Studies research library. She joins **Andrea Mitchell** (Alcohol Research Group) and **Barbara Weiner** (Hazelden) in a growing group of exceptionally skilled individuals who are infusing information technology into the field of addiction treatment.

Candice Pert, PhD, was co-discoverer of the presence of opiate receptor sites in human nerve tissue—a discovery that illuminated the biological underpinnings of addiction and led to the development of new pharmacological adjuncts in addiction treatment.

Katherine Pike founded the Pasadena Council on Alcoholism in 1949. She and her husband, Tom Pike, were among the most articulate national advocates for community-based alcoholism prevention and treatment programs.

Lillian Roth, famed screen actress, announced in 1946 that she was being treated for alcoholism at the Westchester Sanitarium. She depicted her addiction and recovery experiences in the books *I'll Cry Tomorrow* (1954) (also made into a major motion picture) and *Beyond My Worth (1958)*.

Sister Ignatia, the "Angel of Alcoholics Anonymous," collaborated with A.A. co-founder Dr. Robert Smith in the late 1930s on the development of a five-day inpatient treatment program for alcoholism at St. Thomas Hospital in Akron, Ohio. St. Thomas became the model for many mid-century, hospital-based alcoholism units.

Marjorie Smith edited and published the diaries of an anonymous woman (O.W.) in the 1930s. *No Bed of Roses: The Diary of a Lost Soul* (1930) and *God Have Mercy on Me: From the Diaries of a Lost Soul* (1931) revealed the hidden world of addicted women.

Adele Smithers-Fornaci has, through her roles as president of the Christopher D. Smithers Foundation and president of the board of the National Council on Alcoholism and Drug Dependence, provided leadership and philanthropic support to innumerable projects related to alcoholism and drug dependence.

Phyllis Snyder was appointed director of Chicago's Alcoholism Treatment Center in 1957 and served in that role for more than twenty years. She was a central figure in the rise of alcoholism treatment as a professional specialty and an influential advocate for the development of city-sponsored alcoholism programs.

Dr. Agnes Sparks was one of the first female physicians to specialize in addiction medicine. Her articles in the

Journal of Inebriety and other medical journals in the 1890s called attention to the special needs of addicted women.

Nancy Waite-O'Brien, PhD, Vice-President of Clinical Services at Betty Ford Center, represents a new generation of women who have used their tenure of service in the addictions field to assume the highest positions of clinical leadership.

Constance Weisner, Dr.P.H., Professor of Psychiatry at the University of California at San Francisco, is one of the most astute observers of modern addiction treatment. She has studied the evolution of addiction treatment as a system and has helped shape treatment policy by participating in such landmark works as the Institute of Medicine's *Broadening the Base of Treatment for Alcohol Problems*.

Sis Wenger is the Executive Director of the National Association for Children of Alcoholics. She is a long-time educator and advocate on the special needs of children affected by addiction.

Frances Willard was one of the most powerful and respected leaders of the American Temperance Movement. It was under her leadership that the Woman's Christian Temperance Union began rescue work with female inebriates during the late nineteenth century and called for the creation of special facilities for the treatment of addicted women.

Sharon Wilsnack, PhD, is presently Chester Fritz Distinguished Professor in the Department of Neuroscience, University of North Dakota School of Medicine and Health Sciences. She coordinated an international research project on gender and alcohol and served as co-editor of *Alcohol Problems in Women: Antecedents, Consequences, and Intervention* (1984) and *Gender and Alcohol: Individual and Social Perspectives* (1997). Dr. Wilsnack joins **Marian Sandmaier** and **Linda Beckman** PhD, among the modern pioneers whose work brought attention to the special needs of addicted women.

Wyoming Woman was a Delaware Indian prophetess who in 1751 began preaching about the destructive effects of alcohol ("a poison among us"). She set the stage for the rise of many Native American, abstinence-based healing and religious/cultural revitalization movements.

The challenge in writing this article was the lack of space to honor all the past and living pioneers who deserve acknowledgement. I expect many readers to say that I was remiss in leaving this person or that person off the list. I encourage you to write to the Editor of *Counselor* to call attention to these omissions. Such responses will themselves be a testament to the growing contributions of women to worlds of addiction treatment and recovery.

The field of addiction treatment is no longer a man's world, and it is a stronger field because of it. The story of the role of women in the history of addiction, treatment and recovery in America has yet to be fully researched and recorded. It is time for that story to be told.

William L. White is a Senior Research Consultant at Chestnut Health Systems and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

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Citation: White, W. (2005). A question of justice: Recovery and civil rights. Rising: Recovery in Action (Quarterly Journal of The Faces and Voices of Recovery), Summer, p. 6. Posted at **www.williamwhitepapers.com**

A Question of Justice: Recovery and Civil Rights

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During the historical invasion of Turtle Island (North America), Indian leaders asserted that Native peoples' status as sovereign nations granted their right to banish exploitive whiskey traffickers from tribal lands.

In the 1860s, leaders of the Chicago Washingtonian Home set forth the proposition that every industry ought to be responsible for individuals harmed by its products and actions. This proposition led to the allocation of a portion of liquor license and liquor tax revenues in Cook County for the treatment of alcoholism.

In the 1890s, members of the Keeley Leagues (the alumni support group of the Keeley Institutes) marched on the Pennsylvania State Capital to support passage of a Keeley Law that allocated state funds to subsidize alcoholism treatment for those who could not afford it. They argued that access to alcoholism treatment should not be the exclusive privilege of the affluent.

In 1906, patients of the Massachusetts Hospital for Dipsomaniacs and Inebriates organized a protest that exposed abusive conditions within the hospital (medical incompetence, patient neglect and abuse, misallocation of patient fees). Their protest led to the indictment of key staff and the reform of the institution.

In the mid-twentieth century, recovery advocates challenged "morality clauses" in the by-laws of community hospitals that barred admission of alcoholics. Such exclusions were based on the belief that alcoholics were not morally qualified for medical care. Recovery advocates argued that alcoholism was a disease and that those suffering from it should have equal access to health care institutions. During this same era, advocates argued before the courts that public intoxication by the chronic alcoholic was an involuntary act and should be addressed via medical care rather than

incarceration. Their sustained advocacy led to the decriminalization of public intoxication.

These milestones in recovery history constitute early efforts to elevate civil rights issues within addiction-related public education and health reform movements. The stigma and shame attached to addiction have worked against transforming recovery advocacy movements into a more fully formed civil rights movement, but that transformation could occur in the opening decades of the twenty-first century.

Recovering people, long-silenced, are now declaring their presence within and contributions to this culture. We are speaking out against objectifying stereotypes and discriminatory policies that narrow the doorway of entry into recovery. We are confronting discrimination in health and life insurance, housing, education, employment, and social services and are demanding the privileges and benefits available to other American citizens. We are moving beyond our own personal recoveries to become catalysts of social change.

The time to define the American recovery advocacy movement as a civil rights movement has arrived.



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Citation: White, W. & Godley, M. (2005). Addiction treatment outcomes: Who and what can you believe? *Counselor*, 6(3), 52-55. Posted at **www.williamwhitepapers.com**

Addiction Treatment Outcomes: Who and what can you believe?

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Addiction counselors are sometimes asked, "How successful is your program?" or more globally, "Does addiction treatment *really* work?" Responses to such questions can be drawn from one's clinical experience, a study of one's own program, or from studies reported at professional conferences, in professional trade journals or in scientific publications. The problem is that the conclusions drawn from these multiple sources may be inconsistent or even contradictory.

Reporting addiction treatment outcomes has a long, problem-filled history. The first addiction treatment outcome study was conducted in 1874 by Dr. Joseph Turner, founder of the New York State Inebriate Asylum. Subsequent studies, some involving thousands of treated patients (Chamberlain, 1891; Crothers, 1893), became commonplace in the nineteenth century. The percentages of claimed "cures" declined as studies improved methodologically, but honest reporting of these outcomes conflicted with business interests as new competitors (private addiction cure institutes, private sanatoria, and bottled home cures) entered the field claiming 90-100% cure rates. The addictions treatment field in the late nineteenth century was plagued by a tension between the need for objective data to advance scientific knowledge and improve treatment protocol versus the need to claim high success rates to market services and raise funds.

More than a century later, discrepancies remain between addiction treatment outcomes reported in peer-reviewed scientific journals and the outcomes claimed by treatment industry representatives and the representatives of particular treatment programs. The goals of this article are to explore the roots of such discrepancy, to help addiction counselors critically evaluate treatment outcome claims, and to raise awareness of scientifically defensible methods for evaluating treatment outcomes.

Variability of Reported Outcomes

The authors' evolving careers over the past three decades as frontline clinicians, clinical and program directors, and clinical researchers have provided a unique vantage point to examine the discrepancies in outcome reports across the worlds of clinical practice and scientific research. Claims of 50-70%+ success rates for particular programs are common in our

queries of treatment program representatives, and the Internet is filled with treatment claims of 70-100% success rates—rates that far exceed those reported at scientific conferences and in the scientific literature. (A 2001 review of the largest and methodologically rigorous alcoholism treatment outcome studies by Miller, Walters and Bennett reported an average one-year continuous abstinence rate of 24%.) At the marketing and public relations level, we have witnessed promotional material that oversimplifies ("Treatment works") and overstates the complex and highly variable outcomes of addiction treatment (White, 2004). These discrepancies raise the question of who and what one can believe about the effectiveness of addiction treatment.

There are several possible sources of this discrepancy. Clinical outcomes do differ across client populations, addiction treatment programs and even across addiction counselors (Wilbourne & Miller, 2003; McLellan, Woody, Luborsky, & Goehl, 1988). It is certainly possible that some programs simply have far superior treatment services, have more competent individuals delivering these services, treat clients with better prognoses for recovery or some combination of these characteristics. We suspect, however, that the primary cause of these discrepancies lies in the quality of the study methods and procedures upon which statements about effectiveness are made.

Methodological Weaknesses in Local Follow-up Studies

Some claims of treatment success rest on no scientific foundation and instead represent everything from honest estimates to self-serving fabrications. However, the more common problem is that well-intentioned individuals within local programs conduct follow-up studies of discharged clients using methods that are so different from those used in scientific studies as to render the results across these worlds incomparable. Below we identify 10 of the most important criteria that differentiate scientifically rigorous studies of treatment effectiveness from the "home grown," or less rigorous studies.

Motivation for the Study: Addiction treatment programs are under ever-growing pressure to answer questions about their effectiveness. Their need to defend or extol the benefits of treatment can influence the design and conduct of a study in ways that bias study findings. In contrast, the best scientific studies are placed in the hands of trained clinical researchers whose primary goal is to implement the best possible scientific methods to evaluate the effects of particular interventions, not justify the legitimacy of treatment as a cultural institution.

Study Design and Treatment Specification: The question of "Is this treatment intervention effective?" is best answered in the context of, "Compared to what?" Follow-up studies of a single treatment program fail to answer the latter question. In contrast, the strongest studies answer these questions via random assignment of clients to different interventions whose active ingredients are specified in a treatment manual, delivered by staff who have completed competency-based training on the manual, and who are then monitored over time by a clinical supervisor to assure implementation fidelity. This approach allows comparison of effects for two or more treatments.

Inclusion Criteria: The high reported success rates of some programs may reflect a practice euphemistically known as "creaming"—admitting to treatment or including in the study only individuals with the best prognoses for long-term recovery, while excluding those with high problem severity. In contrast, scientific studies of program effectiveness attempt to assure that those being studied are representative of the larger pool of persons in need of such treatment or restrict statements of effectiveness to those persons who share the characteristics of those studied.

Intention to Treat: Reporting success rates solely of "graduates" or those "successfully completing continuing care"—a common practice in program marketing materials and local program evaluations--

inflates treatment outcomes by excluding those clients who failed to complete primary treatment or continuing care. In contrast, scientific studies base their conclusions about the degree of treatment effectiveness on "intent to treat" samples, meaning that once enrolled in the study, even clients who drop out after one day or one session are still included in the main analyses (for retrospective studies this would be the equivalent of including every client admitted during a specified time period, not just those who successfully completed treatment). This is a key point because treatment was *intended* to work for individuals who prematurely dropped out, therefore they must be included all the way through longitudinal follow-up and data analysis. This practice is essential in defining the success and limitations of interventions.

Sample Size: Small samples provide poor statistical power to detect treatment effects upon which conclusions can be drawn, e.g., is the treatment more effective for women than men, when women may make up a very small number of the overall sample. Alternatively, studies with small sample sizes may find a large effect (capitalizing on a few patients with excellent outcomes) that would later dissipate once, for example, 50 patients per condition or more were enrolled, treated, and followed-up. We have seen significant findings occur with 30 clients per condition only to be reduced to clinically trivial differences upon following up 50 clients per condition. Studies with small samples may be helpful in calling for large sample controlled replications, but they should not be relied upon for marketing, policy or program decision making.

Follow-up Rate: The low follow-up rates (less than 50%) that often characterize local treatment program follow-up studies artificially inflate recovery outcomes by excluding those individuals who couldn't be found at follow-up. Research shows that poorer functioning clients are more likely to be lost at follow up (Scott, 2004). The Center for Substance Abuse Treatment requires 80% follow up rates at 6 and 12 months for its discretionary grant programs and recently published follow-up technology is demonstrating consistent rates of 90+% several years after intake (Scott, 2004; Scott & Dennis, 2000; Cottler, Compton, Ben-Adallah, Horne, & Claverie, 1996).

Data Sources and Interviewer Reactivity: Most local program evaluations are based on client self-report data collected through telephone interviews or mail in surveys. In contrast, scientific studies often supplement client self-report with collateral interviews and chemical testing. Local evaluations often use clinical staff with a pre-existing relationship with the client to collect the data. This may introduce a reactive bias where the desire of the client to meet the clinical staff's expectations of complete abstinence leads to false negative self-reports of no or low use. In contrast, scientific studies use trained interviewers who are not affiliated with the treatment program to collect follow-up information.

Outcome Measures: A fundamental flaw in many local outcome studies is the use of a single "(and sometimes undefined) effectiveness measure. All references to "success rates" or "recovery rates" need to be operationally defined in clear and specific terms. The trend in scientific studies is to do pre- and post-treatment, and follow-up comparisons across multiple dimensions, e.g., percent abstinent during a defined period; percent of days abstinent per month, ounces of ethanol consumed per using episode, the number of problems related to use, and other measures of life-health functioning.

Peer-review, the "Gold-standard:" We have been surprised how many programs failed to provide us requested copies of the study upon which a claimed success rate was based. Such secrecy is the antithesis of good science. No study of treatment outcomes is credible until its methods and findings have been subjected to peer review, published, or at least made available for review by others.

Truth-in-Advertising: Some local programs base reports of their effectiveness on a single study from their distant past, even though the clinical design of the program has changed since the original study was conducted. Providers often make

changes to treatment models, including evidenced-based treatment manuals that are designed to be conducted according to the manual protocol! If we "drift" from the "xyz" manual or the treatment program that was evaluated previously---we should not claim that we are doing the "xyz program," or that our program will have a level of effectiveness based on a study for which the results no longer apply.

Improving Local Evaluations of Addiction Treatment

Most local programs do not have the financial and technical resources to design and conduct large randomized clinical trials, but there is much that can be done to improve the scientific integrity of their client follow-up studies. We offer the following prescriptions toward this end:

- vow to conduct the study in the most objective manner possible, using trained experts in clinical research methods to oversee your procedures from *recruitment to treatment* to *follow-up* to *analysis* and *report writing*,
- define the active ingredients of the treatment that is to be evaluated, assure that staff can and do competently deliver those critical ingredients and report dosage (i.e., how much of the treatment did each participant receive),
- report characteristics of clients upon whose experiences clinical outcomes are based,
- use the Consort guidelines (http://www.nature.com/bdj/about/Consort.htm) to report client eligibility, recruitment, enrollment, and attrition; remember to use the "intent to treat" standard,
- use as large a sample as possible, especially if you plan subgroup comparisons,
- achieve at least an 80% follow-up rate or be prepared to carefully limit your conclusions,
- except for pilot or preliminary investigations, report outcomes for the longest possible period you can afford. Ideally, one year post-treatment; but longer is clearly better,
- validate self-report data with collateral interviews and, whenever possible, chemical testing,
- use independent interviewers rather than clinical staff with pre-existing relationships with the study population,
- evaluate outcomes across multiple dimensions (e.g., changes in quantity and frequency of primary and secondary drug consumption and related problems) and multiple measures of health and functioning as might be found in the Global Appraisal of Individual Needs or the Addiction Severity Index,
- be your own worst critic before someone else is—look for alternative explanations for the results obtained and enlist the help of experienced clinicians to help with this, and
- make all studies upon which success claims are made available for professional and public review.

Recruiting local behavioral scientists for consultation on research design, study procedures, analysis, and report writing is highly recommended. Such qualified and experienced consultants may be found at local colleges and universities. There are also excellent written resources for conducting rigorous program evaluation (e.g., Cook and Campbell, 1979) and study guidelines for randomized clinical trials (http://www.nature.com/bdj/about/Consort.htm) that provide expert guidance for conducting methodologically sound studies.

Closing Thoughts

Studies emanating from the research community confirm that addiction treatment can improve the lives of a significant portion of persons experiencing severe substance-related problems, but inflating the potential power of addiction treatment through flawed methods of calculating clinical outcomes can produce unintended harm. Such miscalculations can harm clients by punishing them for failure to achieve unrealistic expectations. Inflated expected outcomes can harm families by creating unrealistic expectations that lead to the abandonment of a family member for whom treatment did not "work" as expected. Such overestimates may also harm the addiction treatment field by contributing to cultural pessimism about the prospects of immediate and sustained recovery.

If we are to avoid such injury and seriously pursue the science to practice agenda, we will need to follow a consistent set of standards to guide both the local conduct of treatment effectiveness studies and the reporting of such studies within professional and public venues. It is time we openly talked about what and who can be believed in the reporting of addiction treatment outcomes.

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Citation: White, W. & Godley, M. (2005). Addiction treatment outcomes: Who and what can you believe? *Counselor*, 6(3), 52-55. Posted at **www.williamwhitepapers.com**

Addiction Treatment Outcomes: Who and what can you believe?

William L. White, MA and Mark Godley, PhD
Chestnut Health Systems

Addiction counselors are sometimes asked, "How successful is your program?" or more globally, "Does addiction treatment *really* work?" Responses to such questions can be drawn from one's clinical experience, a study of one's own program, or from studies reported at professional conferences, in professional trade journals or in scientific publications. The problem is that the conclusions drawn from these multiple sources may be inconsistent or even contradictory.

Reporting addiction treatment outcomes has a long, problem-filled history. The first addiction treatment outcome study was conducted in 1874 by Dr. Joseph Turner, founder of the New York State Inebriate Asylum. Subsequent studies, some involving thousands of treated patients (Chamberlain, 1891; Crothers, 1893), became commonplace in the nineteenth century. The percentages of claimed "cures" declined as studies improved methodologically, but honest reporting of these outcomes conflicted with business interests as new competitors (private addiction cure institutes, private sanatoria, and bottled home cures) entered the field claiming 90-100% cure rates. The addictions treatment field in the late nineteenth century was plagued by a tension between the need for objective data to advance scientific knowledge and improve treatment protocol versus the need to claim high success rates to market services and raise funds.

More than a century later, discrepancies remain between addiction treatment outcomes reported in peer-reviewed scientific journals and the outcomes claimed by treatment industry representatives and the representatives of particular treatment programs. The goals of this article are to explore the roots of such discrepancy, to help addiction counselors critically evaluate treatment outcome claims, and to raise awareness of scientifically defensible methods for evaluating treatment outcomes.

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All in the Family: Alcohol and other Drug Problems, Recovery, Advocacy

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Abstract

Families are intimately involved in the dynamics of the alcohol/other drug problems of family members with these problems. Their adaptations to a baffling and devastating disorder of loved ones are viewed as normal and not in terms of psychopathology. Recovery resources for family members are examined, together with the need for advocacy in the part of families, expressed in the new recovery advocacy movement.

Keywords. Alcohol/other drug problems, families, recovery, advocacy

INTRODUCTION

Family members impacted by alcohol and other drug problems have been long-cursed by social stigma, public neglect, and professional misunderstanding. Parents, spouses, and children of the addicted have hidden their most life-shaping experiences behind a veil of silence and secrecy. The personal stories that they eventually shared with professionals were all too often interpreted in terms of personal psychopathology, rather than normal adaptations to a disorder both baffling and devastating. Throughout the history of addiction in America, family members have been castigated more as causative agents and sources of recovery sabotage than as recovery resources or individuals deserving services in their own right.

Given this history, it is not surprising that family members have most often found healing and purpose when they banded together for their own mutual support and political advocacy. In this two-part essay, we will first explore the history of family perspectives on addiction and recovery through the published work of psychiatrists, psychologists, social workers and addiction

counselors. We will then report the results of focus groups held in Connecticut, New York and Massachusetts with family members impacted by addiction. We close this paper with a discussion of the roles family members are playing in the new recovery advocacy movement.

PART I
HISTORICAL PERSPECTIVES ON FAMILY ADDICTION, TREATMENT, RECOVERY, and ADVOCACY

The American Temperance Movement

America's earliest recognition of chronic drunkenness as a disease was accompanied by recognition of the family as a vessel through which alcohol addiction could be transmitted across generations. In 1835, Robert MacNish set forth this emerging view in his book, *Anatomy of Drunkenness:*

> *Drunkenness appears to be in some measure hereditary. We frequently see it descending from parents to their children. This may undoubtedly often arise from bad example and imitation, but there can be little question that, in many instances, it exists as a family predisposition.* (p.61)

The belief that alcoholism was a product of heredity and parental example grew throughout the nineteenth century and added fuel to a rising eugenics movement that called for the mandatory sterilization of alcoholics and addicts (in addition to the mentally ill and developmentally disabled). The passage of these laws was based on the belief that social problems such as alcoholism were a product of bad breeding and could be eliminated by weeding degenerate families from the culture.

The American Temperance Movement was filled with graphic images of the impact of alcoholism on the family. Reformed drunkards filled temperance pulpits, sharing wrenching stories of the pain and havoc they had wreaked on their families. Temperance plays such as *The Drunkard, One Cup More,* and *The Doom of the Drunkard* portrayed the alcohol-related violence, the economic hardship, and abandonment. Women and children played important roles in the Temperance Movement. Bordin (1990), in her study of Woman's Christian Temperance Union membership, noted that many women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Local temperance society meetings served as therapeutic functions for the daughters, sisters, wives and mothers of alcoholics, and provided a vehicle through which personal pain could be transformed into political advocacy. Beginning with the founding of the Martha Washington Society in 1842, America's early recovery mutual aid societies created auxiliary societies for wives and created junior auxiliaries for children. The "Women's Crusade" and "Children's Crusade" of the 1870s and 1880s brought an unprecedented number of family members into leadership roles in rescue work with alcoholics and the drive for legal prohibition of alcohol.

The Inebriate Asylum Era

Nineteenth- and early 20th-century inebriety literature expressed enormous ambivalence toward the family of the alcoholic and addict. Wives of patients often took up temporary residence in the city nearest the inebriate asylums, so they could provide daily support to their husbands (An Inmate…1869). Wives were viewed as "loyal angels" by the patients, but inebriate asylum staff viewed family members quite differently. While acknowledging the family's role in legally committing the inebriate, taking guardianship of the inebriate's financial affairs, and visiting and supporting the inebriate in treatment; many early treatment professionals saw family

members as hostile interlopers. For example, Palmer, in his 1898 treatise *Inebriety*, had the following to say about wives:

> *The universality of good wives to intemperate husbands suggests an inquiry into the connection they may bear and the influence they may exercise, however innocently, in the downfall of their husbands.* (p. 42)

Nine years later, Cutten in his 1907 *Psychology of Alcoholism* text wrote:

> *The kindest wife and most indulgent parents are very much in the way of numerous cures, and prove to be, instead of the best friends, the worst enemies the alcoholic has.* (p. 325)

Dr. H. H. Kane noted in 1881 that many failed attempts at addiction recovery were due to what today would later be christened family enabling:

> *Very often the relatives, not understanding the meaning of certain symptoms, distressed beyond measure by the pitiful pleadings of the sufferer, will interpose and at once put an end to treatment, thus unwittingly and with well-meaning doing the patient injury of the gravest kind.* (p. 116)

As we will see, there was a thin line between saying that the family could be an obstacle to recovery and saying that the family was a cause of addiction.

Another emerging theme in the nineteenth century is the financial exploitation of family members' anguish and guilt. This was most blatant among the purveyors of bottled and boxed addiction cures, whose advertisements often targeted wives and family members. The most insidious of these claimed that alcoholics could be cured without their voluntary cooperation and, in fact, without their knowledge. Instructions that came with Formula A, for example, directed that 15 to 20 drops of Formula A be surreptitiously placed within the drinker's first drink of the day, and that if this did not induce vomiting, another 15-20 drops were to be added to the second or third drink. These were to be supplemented by sprinkling the contents of Formula A capsules in the drinker's food. Formula A, like many such cures, contained a nauseant-usually fluid extract of ipecac (American Medical Association Health Fraud and Alternative Medicine Collection, Report from Post Office Department, p.3, Box 0030-10). Among the alcoholism-cure products promoted to be secretly administered by family members included the White Star Secret Liquor Cure, The Boston Drug Cure for Drunkenness, Vantox, and Texcum Powders (Helfand, 1996).

There is very little nineteenth-century literature on the impact of addictions other than alcoholism on the family. Most narcotics addicts of this era were white, middle-aged, affluent women whose addictions and their effects on the family were virtually invisible until revealed in occasional literary works, e.g., Eugene O'Neil's autobiographical depiction of his mother's addiction in *Long Day's Journey into Night.*

The Pre-A.A./Al-Anon Years

The opening decades of the twentieth century witnessed the increased influence of psychology and psychiatry upon perceptions of the alcoholic and his/her family. Lay therapy models of alcoholism counseling birthed within the Emmanuel Clinic in Boston dominated thinking about the alcoholic and the alcoholic family. Richard Peabody (1936), the leading lay therapist of this era, believed there were three basic causes of alcoholism: (1) inheritance of a nervous system which was not resistant to alcohol, (2) the effect of the early family environment or (3) the influence of later experiences in marriage, college or work. Peabody emphasized the parental role as a causative agent of alcoholism (his followers were more specific in blaming mothers). In this view,

maternal domination (and a shy, despondent father) led to feelings of inferiority and nervousness, which, in turn, induced alcoholism.

The pioneers of the psychological therapies for the treatment of alcoholism that emerged in the 1930s generally viewed the family of the alcoholic as a nuisance or a threat. The views of Strecker and Chambers (1938) are typical. They noted the wounded pride wives experienced as a result of successful therapy, noted wives' efforts to sabotage treatment to reassert their power and control, and complained of having to deal with the wife's "childish resentments." The goal of working with the family in their view was not engaging the family's involvement but obtaining an agreement for noninterference in the alcoholic's treatment.

Psychoanalysts of the 1930s and 1940s shared similar views. Knight (1938), for example, regularly noted the lack of cooperation with and outright sabotage of treatment by the family. Therapist vacillated between including and excluding family members from the treatment process. Some therapists also demanded abstinence from the family members (Jellinek, 1942). Moore and Gray, in a 1937 article on alcoholism, talked about the need for educating the alcoholic's family and noted: "the person with the greatest need of psychiatric treatment is the marital partner who has *not* become alcoholic" (pp. 381-388).

What is striking in the opening decades of the twentieth century is the utter silence of family members. While they are described in great clinical detail, there are few first person voices conveying their vacillation between hell and hope.

Al-Anon

Alcoholics Anonymous began as a family affair, with alcoholics and their family members attending group meetings together, but the voices of family members were heard only indirectly in these early years (the section of the book Alcoholics Anonymous, entitled "To the Wives" was written by A.A. co-founder Bill Wilson). In the 1940s, wives (and later, wives and husbands) of A.A. members began to band together for mutual support in such places as Long Beach California, Richmond Virginia, and Chicago Illinois. A close reading of early editions of the *A.A. Grapevine* reveals the considerable family activity that was underway. Family members of San Diego California A.A. members organized themselves as "Alcoholics Anonymous Associates" in May of 1946. It was there that the practice of spouses joining an A.A.-affiliated support group *before* their partners joined A.A. began. A May 1947 *Grapevine* article noted regular meetings of a Family Groups in San Pedro and Sugar Hill California. The former was noted to have held annual open meetings that were used to educated doctors, judges, and welfare workers. In July of the same year, an article noted the formation of a "Non-A.A. Group" (N.A.A) for family members in Austin Texas. A similar group, referring to itself as the "A.A. Auxiliary" (A.A.A.), was formed in Rome, Georgia in July of 1947. The founding of another "Non-A.A. Group" in Rochester New York was announced in July of 1948. The Rochester group was the first noted in the *Grapevine* to have adapted the Twelve Steps for use by the husbands and wives of alcoholics. Their first step read: "We admitted we were powerless to help the alcoholic." Formal groups of the wives of A.A. members began to spread, meeting under such other names as A.A. Helpmates, Al-Anon, Alono, and Onala (*A.A. Grapevine*, 1947-1963). The growing number of these groups and their request to be listed in the *A.A. Directory* posed a growing question about the relationship between the family groups and A.A. itself (*Living With an Alcoholic*, 1980). To recognize this growing movement and to clarify its relationship to A.A., Lois Wilson and her friend Anne B. set up a service office in 1951 to support the groups. Their announced goals were:

1. To give cooperation and understanding to the A.A. at home.
2. To live by the Twelve Steps ourselves in order to grow spiritually along with our A.A.
3. To welcome and give comfort to families of new A.A.

They chose the name Al-Anon Family Groups and began responding to information requests from family members, requests that were arriving at A.A. headquarters. In the early days, they called themselves the Clearinghouse Committee, and in 1954, they incorporated as Al-Anon Family Group Headquarters, Inc. Just prior to incorporation, Henrietta S. became Al-Anon's first General Secretary/Executive Director (*Al-Anon: Then and Now*, 1986). Responding to the need for more family-oriented literature, Lois began working on a pamphlet that, with the help of Bill Wilson and editorial assistance from Margaret D. and Ralph P., became the book, *The Al-Anon Family Groups*. The first mimeographed copy of this book made its appearance at the 1955 A.A. International Convention in St. Louis.

Al-Anon meetings and literature evolved from a focus on the alcoholic to the emotional and spiritual health of Al-Anon members. As Lois Wilson (1994) has noted:

> *I suppose the seeds of Al-Anon actually germinated when the families of early A.A. members first felt the stirrings of their own regeneration, and began to do something about it* (p. 172).

Another family milestone was the founding of Alateen in 1957, which provided a support group structure for persons 12 to 20 whose lives had been affected by alcoholism.

Al-Anon and Alateen constitute a historical milestone in their focus on the needs of the alcoholic's family members. When pondering the single most important lesson she had learned in Al-Anon, Lois Wilson later stated simply:

> *…we cannot change another human being-only ourselves. By living our own lives to the best of our ability, by loving deeply and not trying to mold another to our wishes, we can help not only ourselves but that other also.* (Wilson, 1994, p. i)

Bill Wilson wrote about the dynamics of the alcoholic marriage at length in the 1952 publication *Twelve Steps and Twelve Traditions*. Here he described how alcoholism turned the alcoholic into a "sick and irresponsible child" and the non-alcoholic spouse into a resentful mother-a method of caring that the alcoholic "alternately loves and hates." Bill went on to describe how this fixed pattern is disrupted by sobriety and how the spouse may resent that A.A. has been able to do what his or her efforts could not and that the marriage in early recovery is often characterized not by grateful bliss but by blame and strain (Twelve Steps and Twelve Traditions, 1981). What Al-Anon provided was guidance through this reconstruction of intimate relationships in the transition from alcoholism to recovery.

While Al-Anon introduced family perspectives that would later exert significant influence on the treatment of alcoholism, family perspectives on and involvement in narcotic addiction treatment during the middle-twentieth century were plagued by problems of distance. Those addicts treated at Lexington and Ft. Worth, the two federal public health hospitals that opened in the 1930s, came from all over the United States. The lack of community-based treatment resources meant that family members were rarely involved in the treatment process. There is a striking absence of family perspective in the addiction literature during this era. References to family in the literature are drawn primarily from addict self-report of his/her family circumstances.

Family Advocacy and the Modern Alcoholism Movement

In 1944, Marty Mann, the first woman to achieve sustained sobriety in A.A., founded the National Committee for Education on Alcoholism (Mann, 1944). Mann's goal was nothing short of changing how America viewed alcoholism and the alcoholic. To achieve that goal, Mann organized local affiliates across the country who provided alcoholism-related information and education, worked to open hospital doors for detoxification, and encouraged the development of alcoholism treatment and convalescent centers. Family members impacted by alcoholism and blessed by recovery played important roles in this advocacy movement that laid the foundation of modern addiction treatment.

Understanding the Alcoholic Family as a System (1950s and 1960s)

Family perspectives in the 1950s shifted from looking at the alcoholic and the alcoholic spouse as individuals to looking at the alcoholic couple as a dynamic system. The focus on the alcoholic wife had shifted to a focus on the alcoholic marriage. Of particular interest was the process through which the male alcoholic and his wife struck an "interpersonal bargain" to get personal needs met and maintain some degree of homeostasis in the face of alcohol's assault on the marital relationship. A milestone in this shifting view was the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism" in the *Quarterly Journal of Studies on Alcohol*. Jackson went on to study how alcoholism elicited a wide variety of developmental problems in children of alcoholics (Jackson, 1964). The growing interest in family dynamics during the 1950s and 1960s was evident in the publication of new educational materials such as *Alcoholism: A Family Illness* (a Smithers Foundation publication) and new Al-Anon pamphlets such as *The Stag Line, What's Next? Asks the Husband of an Alcoholic, My Wife is an Alcoholic,* and *Al-Anon IS for Men* that recognized the needs of men married to alcoholic women.

The focus of family studies evolved through several stages: the alcoholic wife, the alcoholic marriage, concurrent group therapy of alcoholics and their wives, multiple couple and multiple-family group therapy approaches, concurrent inpatient/residential treatment of the alcoholic and the alcoholic spouse, and speculations on the nature of the alcoholic family as a dynamic system. What came out of these studies was the concept of "co-alcoholism"-the extension of the disease process to those people, particularly the spouse, who were most intimately involved with the alcoholic.

There are two underlying themes that permeate family studies of addiction in the 1950s and 1960s. The first are studies that document the adaptations that occur within the family in response to addiction and the addiction-related deterioration in role performance of a family member. The second is a suggestion that the marital or family environment is actually an agent in initiating and sustaining addiction. The former studies depict members as innocent victims; the latter depict family members and particularly the wife of the male alcoholic as an "etiological agent" or a factor "complicating the illness." Jackson (1962), and more recently Chaudron and Wilkinson (1988), have reviewed professional literature that not-so-subtly implied that the pathology of alcoholism was rooted not in the alcoholic man, but in his wife. (This literature was strangely silent on the husbands of alcoholic women.)

Alcoholics' wives were increasingly depicted as having chosen alcoholics in order to meet their own dependency needs. Two separately authored articles illustrate this view. In the first article, Thelma Whalen (1944, pp.632-641) described the wives of alcoholics she counseled at a family service agency in Dallas Texas. She noted that "the wife of the alcoholic has as poorly integrated a personality as her husband" and that the wife, as surely as the alcoholic, was responsible for creating the marriage and the "sordid sequence of marital misery" that

followed. Whalen describe alcoholics' wives as falling into one of four styles: (1) Suffering Susan, whose marriage and loyalty to the alcoholic was related to her need for self-punishment, (2) Controlling Catherine, who chose the alcoholic because of his inferiority and her own need to dominate, (3) Wavering Winnifred, who stayed with her alcoholic husband out of her need to be needed, and (4) Punishing Polly, whose relationship with her alcoholic husband was comparable to that of a "boa constrictor to a rabbit."

In the second article, Samuel Futterman (1953) described the prototypical wife of an alcoholic as an inadequate woman who gains ego strength only in relationship to her husband's weakness. Futterman accused the alcoholic's wife of maintaining her "illusion of indispensability" at her husband's expense by inciting his drinking episodes. He noted that it was only through such behavior that the wife could escape the depression she experienced during the periods in which her husband was sober and adequately functioning.

The general profile of the alcoholic wife depicted in this early literature was that of a woman who was neurotic, sexually repressed, dependent, man-hating, domineering, mothering, guilty and masochistic, and/or hostile and nagging (Day, 1961). The typical therapist's view of the wife of the alcoholic was generally one of "I'd drink, too, if I were married to her" (Reddy, 1971, p.1).

Al-Anon not only provided a sustained source of support to family members affected by alcoholism, but also brought together in one place a large enough pool of alcoholic wives to allow researchers to begin to test some of their propositions regarding these women's supposed pathology. By the early 1960s, objective studies began to call into question the 1950s portrayal of the alcoholic wife as having selected and remained with her husband out of her own deep emotional disturbance (Corder, Hendricks, & Corder, 1964).

Wives were not alone in being blamed for the alcoholism of their mates. Day, in her 1961 review of the alcoholism literature also noted a body of opinion suggesting that the etiology of male alcoholism could be found in the alcoholic's family of origin, particularly within the mother-son relationship. This literature emphasized the degree to which maternal domination and overindulgence created the future alcoholic's low tolerance for pain and frustration and stifled his ability to become independent and responsible. Other contributing factors in the family included a stern, autocratic father and conflicting maternal and paternal attitudes toward drinking (Day, 1961). Marking the continuity of this tradition, parents were consistently blamed as their children began illicit experimentation in the 1960s. It was in this context of blame that family therapy emerged as a primary mode of treatment for adolescent substance use disorders (Edwards & Steinglass, 1995; Liddle & Dakof, 1995).

"Family Programs" (1950s-1970s)

Most significant in the 1950s and 1960s were the emergence of explicitly family-oriented alcoholism treatment models, such as the outpatient counseling approach developed at Johns Hopkins Hospital that utilized parallel group therapy processes for alcoholics and their wives. One of the earliest family-oriented inpatient treatment approaches was initiated in 1965 at the Sandstone Hospital in Minnesota. Dr. Charles Cooper created a "Family-In" program in which families of alcoholic patients came to Sandstone for two to three days of residential, family-focused treatment (Richeson, 1978). Two other programs, Lutheran General Hospital in Illinois and Hazelden in Minnesota also experimented with residential "family week" and "family weekend" programs in the 1960s.

At Lutheran General, the original goal was to have family members live in apartments above Lutheran General's Alcoholism Treatment Center (ATC) so that they could fully participate in treatment, but these plans were abandoned when insurance companies refused to pay for the extra expense that was incurred. In spite of this setback, efforts to increase family involvement in treatment at Lutheran

General continued through the early years. An early "family night" program consisted of a lecture/discussion group. In 1978, a half-day Saturday program using Al-Anon volunteers was added, and in 1979 a formal Family Treatment Program was implemented, consisting of a three-day off-site residential retreat. Later iterations included a residential weekend model. Lutheran General's response to the families of alcoholics had two phases. The first phase was to seek family involvement because of the ways in which family members could enrich the alcoholic's treatment experience. The second phase, which began to emerge in the mid-1970s, was the recognition that family members needed and deserved treatment and support services in their own right.

A key source of family advocacy was the staff hired to work in the ATC who had extensive prior Al-Anon experience. The initiation of a formal alcoholism counselor-training program increased the involvement of Al-Anon members in the ATC. A.A. and Al-Anon members, many of them volunteers, enrolled in the training program and formed a pool from which new counselors could be hired. As the number of people with Al-Anon experience and a family-oriented perspective on alcoholism recovery increased at Lutheran General, these perspectives became integrated into Lutheran General's clinical training and public education programs.

The conceptualization of addiction as a "family disease" opened the door to exploring how this disease altered family structure (roles and subsystem interactions), family rules, family rituals, and the family's boundary transactions with the outside world. Studies of how alcoholism disrupted family rituals (e.g., meals and holidays) concluded that the disruption of such rituals increased the likelihood of intergenerational transmission of alcoholism (Wolin, Bennett, & Noonan, 1979).

The popularization of transactional analysis (TA) theory and techniques in the 1970s again shifted the focus from the effects of alcoholism on the family to the role of the family in the etiology of alcoholism. Within in the TA framework, alcoholism is the product of disordered family and social communication. Steiner (1971) posited three alcoholic roles or games: "Drunk and Proud," "Lush," and "Wino." Each of these games, as described by Steiner, involved manipulating others into the roles of persecutor, patsy, connection or rescuer. The games provide a guilt-free means of expressing aggression, an avoidance of overt anger, a projection of blame, and social attention. It was Steiner's belief that such roles could be revealed and changed through the process of therapeutic self-examination.

Denial, Enabling and Family Intervention (1970s)

A major corollary of the proposition that alcoholism is a family disease was that family homeostasis was maintained through the mechanisms of denial (portrayed metaphorically as the elephant in the living room that no one acknowledges) and enabling (any actions which prevent the alcoholic from experiencing the consequences of their drinking behavior). A further corollary was that acknowledging the problem and adopting a pattern of tough love could speed up the day when the alcoholic "hit bottom" and initiated recovery. Reverend Vern Johnson felt there had to be a better way to intervene in alcoholism than to sit and wait for the alcoholic to hit bottom. He developed a technology of family intervention through which the bottom could be raised to meet the alcoholic. He pioneered the use of a loving confrontation between the alcoholic and those who cared for the alcoholic to precipitate a crisis that most often resulted in the alcoholic's entry into alcoholism treatment. This concept was spread through a charitable foundation (the Johnson Institute) and through Johnson's publications, e.g., *I'll Quit Tomorrow* (1973/1980), which sold more than 100,000 copies.

The Family/Children of Alcoholics and the Codependency Movement (1980s)

Two overlapping movements emerged in the 1980s. The first focused on the special needs of children of alcoholics- an exploration that led to the concept of "co-alcoholism" or "para-alcoholism" (Greenleaf, 1981). During the early to middle 1980s, the work of Claudia Black and Sharon Wegscheider-Cruse graphically depicted the psychological and developmental consequences of parental alcoholism on children and catalogued how these consequences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). This marked a significant shift, in which the alcoholic's family members were viewed, not simply as sources of support for the alcoholic's recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields-counseling children and adult children of alcoholics- and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACOA) groups were formed within Al-Anon-some 1,100 by 1986-and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995).

As this movement took off, the extension of these findings to children and adult children who had been raised in other types of dysfunctional families marked a transition between the concept of co-alcoholism and the newly emerging concept of "codependence." The writings of Karen Horney, Erich Fromm, and other psychologists were used to create the concept of codependency (Melody, Miller & Miller, 1989). Dr. Timmen Cermak (1986a, b) conceptualized codependency as a "disease," proposed criteria for its medical diagnosis, and advocated that the major insurance carriers reimburse treatment of this disease. Addiction treatment programs began offering codependency treatment tracks and extending stays of alcoholics and addicts in treatment because of their "ACOA issues" or "codependency issues." Melodie Beattie launched a veritable social phenomenon with the 1987 publication of her book *Codependent No More.* She later defined five "core symptoms" of codependency: (1) difficulty experiencing appropriate levels of self-esteem, (2) difficulty setting functional boundaries, (3) difficulty owning our own reality, (4) difficulty acknowledging and meeting our own needs and wants, and (5) difficulty experiencing and expressing our reality moderately (Melody, Miller and Miller, 1989). Adding fuel to this movement was the publication the following year of John Bradshaw's *Healing the Shame That Binds You* and his highly popular PBS television series that was based on the book. A whole nation seemed to be riveted on the exploration of the "dysfunctional family" and on the extension of this concept to the workplace, and to society as a whole. This new movement also spawned its own Twelve-Step adaptation, Co-Dependents Anonymous, which by 1990 had more than 1,600 registered groups (Makela, Arminen, Bloomfield, Eisenbach-Strangl, Bergmark, Kurube and others, 1996).

The ACOA and codependency movements left many legacies. For the first time, children and adult children of alcoholics were admitted as primary patients and given a primary diagnosis as well as their own individualized treatment. These movements gave many people a heightened understanding of their own family-of-origin experiences. If there is a clear legacy from the ACOA movement it is the experiential understanding that childhood trauma can unfold developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors. The codependency movement did bear unanticipated fruit via an ideological and financial backlash that hurt the movement itself and the broader addiction treatment community from which it had been spawned.

The Codependency Backlash (1990-1995)

The backlash against the concept of codependency and its commercialized applications came from many quarters (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992). The most strident criticisms included the following:

- The definitions of codependency are so inclusive as to lack any clinical utility.
- The symptoms of codependency inordinately target women have been raised to cultivate; codependency turns social pathology into psychopathology. Energy is turned toward inner healing rather than political activism and environmental change.
- By defining the problem of "women who love too much" as one of psychopathology, we fail to hold abusive men accountable for their neglectful, demeaning and violent behavior.
- The movement sets up a milieu in which women bond out of their weakness rather than their strength (Kasl, 1992).
- The movement infantilizes its members as "Adult Children" and traps them at an immature stage of development.

In the end, it was not philosophical debate but economics that doomed the codependency movement. An aggressive system of managed behavioral health care led to a rapid erosion of first the length of treatment and then an erosion of the number of private and hospital-based addiction treatment programs. In that change, many family programs disappeared. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that it would be financial suicide to provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions.

Family Recovery Research: The New Frontier (Late 1980s-1990s)

Since 1989, Drs. Stephanie Brown and Virginia Lewis have worked to construct the developmental stages of family recovery from addiction. Their preliminary findings challenge the prevailing expectation that families can rapidly move toward health with the initiation of alcoholism recovery. They found in their research that the emotional turbulence within the family produced by addiction continues well into the first three to five years of recovery. Family recovery begins with what are, in essence, individual recoveries of its members. Without "holding environments" to sustain these individual recoveries until couple and family relationships can be reconstructed, the risk of collapse and disintegration of the family is quite high. Children older than twelve may have great difficulty participating in this family-making at a time they are moving toward individuation and separation from the family. A major implication of this research is the notion that children and families go through a "trauma of recovery"-a readjustment of expectations required by their continued psychological isolation from the addicted parent going through early recovery (Brown, 1994). Continued research on families in recovery is likely to reveal the diversity of family addiction and recovery experiences. The response of families to alcoholism and other addictive diseases is not a homogenous one that can be depicted in a single reductionist model. The diversity of family life is as wonderful in its capacity for resilience as it is sometimes horrifying in its capacity for cruelty. Each family must be its own model. Intervention into families must by characterized by gentleness and humility rather than by clinical arrogance born of knowing THE truth about the impact of addiction and recovery on the family.

Evolution of Family-Oriented Treatment

Family treatment evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, groups for wives of alcoholics, conjoint marital therapy, residential or outpatient family education, and primary treatment for family members that focused on their individual recovery. Another nuance that emerged in family programming in addiction treatment programs in the past 20 years was the effort to break intergenerational patterns of alcohol- and other drug-related problems. These efforts, particularly those that emerged in programs designed to treat addicted women with histories of child neglect and child abuse, began with simultaneous but separate interventions with addicted mothers and their children, then focused attention on enhancing the health of the family as a unit. Combining treatment services for parents and children, parenting training, and family therapy, they sought to decrease the likelihood that the children of today's clients would recapitulate these problems as they moved into their own adolescence and adulthood (White, Woll, & Webber, in press).

PART II
FAMILIES AND THE NEW RECOVERY ADVOCACY MOVEMENT

The 1980s and 1990s witnessed significant changes in the cultural perception of people with severe and persistent alcohol and other drug problems. Such problems were re-stigmatized (positive images of addiction and recovery, e.g., First Lady Betty Ford, were replaced by images that evoked fear and pessimism), demedicalized (redefined as moral problems rather than medical problems), and recriminalized (persons with these problems were transferred from systems of compassion and care to systems of control and punishment). In response to these new changes, grassroots recovery advocacy organizations began to again organize to change how America viewed addiction and those addicted. The strength of this movement, which is led by people in addiction recovery and their family members, continues to reside in its work in local communities, although efforts to forge a national-level movement are underway.

The Experience of Family Members as Advocates

To develop a better understanding of the role of family members in this new recovery advocacy movement, the authors conducted and analyzed the results of five focus group meetings of individuals whose families had been impacted by addiction and/or recovery. The meetings were hosted by the Connecticut Community for Addiction Recovery. The focus groups were conducted in the communities of Hartford, CT, Wethersfield, CT, New Haven, CT, Springfield, MA, New City, NY between the summer of 2002 and the spring of 2003. A total of 56 family members participated in the focus groups. Each focus group lasted approximately 2 hours. The members of each focus group were asked to respond to the same set of questions related to family experiences with addiction, recovery and recovery advocacy.

In the remainder of this paper, we will explore the experiences of family advocates in this new movement and end with a discussion of the future of family members as recovery advocates.

The Lived Experience of Stigma

Focus group members often opened with accounts of what it was like to live with the shame and stigma of addiction. Most striking in these accounts were repeated references to the silences that pervaded their lives-silences that grew out of a larger cultural silence about addiction.

> *I grew up in a small, French Canadian town in Northern Maine. There were and are so many alcoholics. Everybody knew our family and our situation (alcoholism), but yet nobody talked about it.*

We were very good at keeping the secret (alcoholism). There was the shame and it was very powerful.

For some this shame was magnified by cultural stereotypes of who was and was not supposed to have alcohol and drug problems.

The problem wasn't alcohol; it was crack cocaine. Where we lived this was viewed as a problem of the intercity ghetto. When our own college-educated son in the suburbs developed this problem, it was really hard to talk to others about it. This was not something our family and friends could see happening in their world. It was our shameful secret.

Such cultural silence made it very difficult for family members to come to grips with the reality of what was happening within their own families.

I thought, "My son can't be a heroin addict." When he went through treatment the first time, I thought, "Now he's fine." After treatment, I thought, "Okay, now we can all go back to normal." I didn't have a clue. I thought my son had a little problem-a little problem that went on to kill him.

My son made something very clear to me some time before he died. I had always thought of junkies as these depraved guys on the streets, and my son said to me one day, "Mom I am that junky. Don't you understand that there isn't a difference between me and that guy?" That's when it really hit me! Today when I see some poor person strung out on the street, I remind myself that this lost soul has a family like mine somewhere. It is sad that people don't understand this.

People would come to my house and see my son's picture, my son that passed away, and they couldn't believe it when I told them that he died last year of a drug overdose. They couldn't believe that he was a normal boy who went fishing and grew up to have two children and a loving family. People think of junkies as people who don't have families that care about them. What no one understands is that these junkies are our sons and daughters and brothers and sisters.

The shame attached to female addiction was greater than that for males.

Maybe this gender thing is old fashioned, but for my mother, it was so much more treacherous for her. She only went to women's meetings. A lot of people knew because when things were bad with her, it wasn't the kind of thing you could hide. But there still wasn't the same kind of openness you see with male family members in recovery.

I am proud of my father's addiction and recovery, but I have had a hard time discussing my mother's addiction and recovery, and my sister's addiction-related death.

There were also differences noted between family experience and disclosure of that experience based on whether the addicted family member was in recovery or still using.

There is a big difference between talking about a family member in recovery and one who's active. When my sister was actively using, the shame was overwhelming. I didn't really want to get into it at all. Once there is the success of recovery, it is a whole lot easier. Then you feel you can share in the pride and success of recovery. But when it's going on, it's very hard. With all the things that addicts do, even with people who are close to you, you don't want to disclose the gory details.

It was often in encounters with professional helpers that family members had to first confront the reality of addiction within their families. Yet focus group members repeatedly talked about the shame they were made to experience within these same institutions.

> *You feel dirty when you're standing in the emergency room and your child is there for a drug overdose.*

> *Interacting with some professionals is like a belly punch. One of them said to me, "I know what to do with addicts: you should put them on an island like Alcatraz and drop food and guns to let them take care of themselves." He said this in front of me. I just wanted to go into another room and cry.*

> *If someone had died in a car accident, they would take the arriving family members to a room and talk to them in a comforting way. When we arrived after being told my son had died of an overdose, they said you better hurry and say your good-byes because the Medical Examiner is coming to pick up his body at midnight. It was like he was nothing-my 24-year-old baby. Nobody walked me in. Nobody got my mother a chair. There was no social worker. They didn't ask if they could call a priest. They didn't ask what funeral home we wanted contacted. Nobody was there to help. There was no privacy-we were out in the middle of the lobby. Nobody took us into a private room. There was nothing.*

One focus group member noted that procedures designed to protect those who are addicted even reflects this stigma.

> *Sometimes I get so angry at the system. One of the things that I think is so detrimental is that the professionals can't tell me whether my daughter is in treatment or not. You don't have to tell me personal information that she has disclosed; I just want to know that she is there and is okay. I don't know where she is. She may be dead on the street. I've been concerned for 6 or 7 days. There is no other medical condition in which family members are so shut out and deprived of information. This is the only disease that even professionals can't talk about. I hope the removal of stigma will make it easier for those in my situation to get information about the status of our family member.*

During such interactions, family members reported hearing more therapeutic pessimism than hope.

> *A number of professionals that know my daughter and about her addiction have told me that she is hardcore and that she will never recover. I can't say I don't believe them, but I refuse to believe them.*

Toward Family-Inclusive Recovery Language

People recovering from addiction have evolved a language (e.g., recovering/recovered) and rituals (e.g., sobriety birthdays) to describe and celebrate their experience. Language and rituals for family members is much less defined. Some refer to themselves as "families in recovery" or a "family member in recovery," even though some focus group members felt such terms were ambiguous and confusing.

> *The term recovery is so broad it is hard to get handle on what we mean by it. The term doesn't capture the diversity of ways families experience addiction and the ways family members restore their own disordered health. I wish we could come up with a better term.*

> *I think my family members would be offended if they were known as a "family in recovery." It has a pejorative connotation.*

We could refer to ourselves as survivors of a family member's addiction or perhaps we could all wear a nametag that says "Caution: Family in Renovation."

Other family members found it difficult to apply the term when their loved one was still actively using.

The only time I'm in recovery is when my daughter is in rehab. That's because I sleep well and I know that she's being taken care of and doing something.

In the end, most focus group members felt comfortable with the term recovery but also felt family members should be able to select the term that best depicts their experience. They clearly see themselves as being in recovery, and they can pinpoint or approximate when they started on the road to recovery. They are interested in being equal partners with their formerly addicted loved ones in a recovery process and feel that use of recovery as a term for their experience enhanced understanding and acceptance by those in direct recovery from addiction. For some family members, the term recovery implies a retrieval of what was lost through addiction (e.g., trust, economic security, intimacy, laughter). For others, such as those whose family member died an addiction-related death, the term recovery implies the long process of grieving and healing.

Persons recovering from addiction use the date that they stopped drug use as their point of recovery initiation and often celebrate that date similar to a birthday. Family members have much greater difficulty pinpointing the initiation of their own recovery process. Some use the recovery initiation date of their family member while others note a particular milestone in their own healing or growth.

It's a long time before you believe it's for real. My father used to celebrate his sobriety anniversary with coins and all that stuff, but it wasn't until he got 7 or 8 years in that we started to believe it. I am not sure I can mark the date for me as a family member, but there clearly was a date when he stopped.

You could pinpoint the period when you understood and stopped enabling, but I think that process is gradual. It's hard to pick a date. It's cumulative.

Marking recovery by enabling alone would be difficult. Enabling is one of the hardest words to deal with. One day you think you're enabling and the next day you do the same thing and you're helping out.

For me events have more of an impact than a date. His last rehab was very eventful for the both of us. I saw a change in him. The return of his soul is the only way I can describe it. The new place that he was at means more to me than any date. It's a developmental process.

Another approach to defining recovery initiation for family members is to focus on the stage at which the member stopped reacting to the addicted family member and focused instead on their own needs and aspirations.

The Decision to Keep or Break Silence: Responses to the Family Addiction/Recovery Story

Family members have three levels at which silence can be broken regarding their experiences with an alcohol- or other drug-addicted family member. These levels mark the stages between personal recovery and political advocacy.

Breaking silence to others cannot occur until there is a breakthrough of insight that allows one to reconstruct the perception of the addicted family member. Many focus group members noted the importance of

such breakthroughs. What this revealed was that silence must be broken within the self before it can be broken to others.

> *I talk to myself. There was a point at somewhere maybe 15 or 20 years ago that I really started to delve into what is this alcoholic family that I grew up in? I reached a point where I accepted the fact that my father was an alcoholic, and I started to get involved in a lot of different things. There was a clear point at which how I saw him and myself started to shift. That was when I decided I wasn't going to be ashamed any more.*
>
> *You have to make sense of what happened and heal yourself before you can carry a message of hope to others. I came to realize that my son had a disease. You can forgive somebody for having cancer; why can't you forgive them for having the disease of addiction? The terrible things they do are part of their disease. My son did a lot of terrible things, but it never meant that he wasn't a good person or that he didn't love me.*

The helpfulness of these new insights opens the doorway for disclosure to others. One of the most difficult arenas for such disclosure involves other family members. The second level of silence-breaking occurs within the family itself. Even some of the most articulate advocates-persons who have championed recovery in all manner of public forums-confessed the difficulty they had talking with other family members about the experience with addiction. Few topics generated such lengthy and detailed responses.

> *I found it easier to talk to people outside of my family…my son is an addict, and I've never even to this day expressed those words to my family. When he was 17 and he started drinking they said it was just a stage and not to worry about it. They know he's been in rehab and on probation, but we've never discussed these things in detail. Part of the reason that I never told them about his addiction was that I felt it would change how they acted towards him and I didn't want that to happen.*
>
> *I have a problem talking about all this with certain members of my family. They have a different outlook on life. They have to shop at Bloomingdales. They just can't shop anywhere else. With certain people, you just can't go there with this subject.*
>
> *I was given an award, not too long ago, and my siblings attended. After my talk on my involvement in the recovery advocacy movement, my wife asked me why I hadn't mentioned my father's alcoholism. I didn't dare broach this subject then for fear of upsetting my siblings. I was silent because I didn't want to have my whole family teed off at me for acknowledging that my father was an alcoholic. This was fifty years of stigma and shame still influencing my behavior.*
>
> *I think we had a harder time with this because it's not a parent who is addicted but our own child. With a child, it is hard not to feel responsible. You are seen as having failed in a vital part of your life. People think that you somehow allowed your kid to become addicted. I have not shared this with some of my own siblings. I have four siblings, but have only talked about my son's addiction with one.*
>
> *The risk that I face is alienation of my siblings, especially with my sister, which is interesting since her husband died of alcoholism. Our relationship has developed in a unique way and I don't want to ruin that. Besides, protecting the alcoholic is still ingrained in me after all those*

years. When I first spoke about my father's alcoholism at a CCAR meeting, I started crying. I didn't realize I would react that way. So there is also the risk of embarrassment in the presence of one's family. My brother is coming down shortly and this obviously won't be a topic. My family knows what I'm doing but I don't push it too far.

I've talked to my mother about my advocacy work, but she's not too excited about it. I've tried to talk to all my brothers and sisters about what I'm involved in and they have provided ambivalent support for my going public with our story.

A person in our group wanted to speak publicly but her daughter was very upset and thought it was simply an airing of the family's dirty laundry in public. It took this woman almost three months to explain to her daughter and have her daughter come around to the fact that what she was doing was very important.

We have CCAR members who are active with us but will not speak publicly because their addicted family members refuse to let them do so.

Going Public

The decision to go public with one's family story of addiction or recovery is a highly personal one. Perhaps the first obstacle to overcome is the anticipation of judgments that others will make.

I think the risk that you face, is what people are going to think. When I tell them what happened to my son, they give me a look and just roll their eyes. I can see that they really don't believe me. I can hear their minds saying that my son was no good and that I must have done something wrong. I risk those judgments for the sake of my son and every other family that could face the nightmare I have lived through.

When I considered going public, all I could think of was my neighbors. I knew I would run this risk of them judging me and having them wonder what I did wrong. I wanted to be thought of as a good parent, but there were several instances when my son acted up in our neighborhood. I had to get past the thought of those people judging me.

I don't care what people think: I will tell the truth of our experience. I loved my grandson, and I hope I can help other people by telling them our story. I don't care if it's in the newspaper. It is the truth of what happened in our life. We went through a lot of pain and we're still recovering.

Most focus groups members talked about having passed through the stage of their concerns about the judgment of others to a place where the message was more important than their potential embarrassment. The first element of that message was that addiction could touch any family and the devastating impact of addiction upon the family as a whole. The second element was about the potential for recovery and the process of recovery for the individual and the family. The potential benefit of this message to others eventually outweighed concerns about personal privacy. There was also in the decision to go public a dimension of anger: anger that their pain could have been lessened if addiction had not been so shrouded in shame and silence.

Family advocacy is important due to the demoralization and anger families often experience through multiple episodes of recovery initiation and relapse. Families need to know that there are permanent solutions to addiction and that there is hope for their loved one and their family. Families telling their stories of survival, forgiveness and reconciliation are powerful antidotes to

the hopelessness that so often pervades the perception of addiction in this culture.

Parents who have lost children to addiction face a special challenge working in recovery advocacy. It is sometimes hard for these parents to work with individuals and families in sustained recovery. Through these relationships they must face the question of why their family was not included among the success stories. For our focus group members, the potential value of their stories to other parents and the larger community overcame such questioning. Most committed their work in advocacy to the loving memories of their lost children.

What family members do is shine a light on the shrouded world of addiction and recovery.

> *When family members speak out, they normalize the addiction experience. When I publicly declare, "I'm a member of a family that has been wounded by addiction," I'm saying that this problem can touch anywhere, that I'm not different than you are. What we can do as family members is try to help others understand what they are dealing with. Our job is to take some of the stigma off being a family touched by addiction and take away the guilt and shame that comes with that.*

When people openly talk about stigmatized issues and experiences to others, there is no cultural etiquette to define what is expected from those hearing this account. The inclination is for people to offer advice about how the problem can be solved.

> *If I tell you my lawn is bad and you tell me to put Scotts on four times a year and then I don't do it, you're going to be upset with me because I didn't take your advice. Sometimes we don't talk because we don't want the advice. We just want them to listen to what we are going through. We need to be honest with people and tell them we are not asking for advice. We need to tell them we have had advice from all quarters, that what we need now is a sympathetic ear and understanding.*

One of the issues that arises following the decision to put a public face and voice on the family experience of addiction and recovery is how to tell one's story as a family member without bringing embarrassment to the addicted or recovering family member.

> *Our son lives and works in the area where we live. I've always been conscious of how my public disclosures could affect him and his business. So I don't say anything unless he says it is all right, or I know he has talked about it. I feel very protective about that. He is in business for himself and he's doing very well, but it's an occupation that requires people's trust. I wouldn't want to do anything to hurt that. It is very important that you have the support of the member, if you are going to speak out, otherwise it could have an adverse effect.*
>
> *This is our son's private place and we've decided that it is not our privilege to talk about that in forums that would bring embarrassment to him. He's part of our local community and we feel we don't have the privilege to publicly tell his story here. We can support him and this movement in ways other than our story.*
>
> *The way I handle this is to not go into a lot of details about his* [addicted family member's] *experience. I try to keep the story to what I experienced.*
>
> *It's not the concerns for myself but for my children, if one of their peers finds out their dad is an alcoholic. How much do I say as a parent and where do I draw the line to keep their life private? I don't stop myself in saying*

what I have to say but I kind of watch it sometimes because of them.

I think we have to be discrete. If I'm going to disclose my story in a public forum, I'm not going to give all the details. I certainly have to take into consideration how disclosing this story will affect my family. Otherwise, I am back to being a self-centered person.

Not everyone is suited to tell their story to a local newspaper or speak before a group of legislators. The personal vulnerability of such disclosure is a reality, but many focus group members talked about how the risks of recovery advocacy were diminished when they stood with large numbers of other people in recovery.

I go to Legislative Day and to the Recovery Walks where there are hundreds or thousands of other people. Those activities are less personally vulnerable because of the sheer number of people who are there.

Some family members expressed concern about potential embarrassment brought to children within the family. The following comment underscores just how personal is the decision and timing of recovery advocacy activities.

Our children are at an age where they want to be like everyone else. They don't want to stand out in any way. So we have been careful to talk to them about when and how we tell our story at a public level. We could even reach a period where we don't tell our story publicly for a while if we decided that it would make our children too uncomfortable.

The fear of potential embarrassment is often overcome by pain, grief, anger, or gratitude.

I refuse to let my son die with that stigma over his head. If it takes to the day I die, I'm going to fight to get rid of the shame and stigma attached to addiction.

There was Al-Anon, but there was nothing there for parents who have lost their sons or daughters to addiction. That's what I committed myself to change.

The women in this group have all lost children to drug overdoses. If we don't speak out, our children will have died in vain.

Recovery Mutual Support and Recovery Advocacy

Family members made several key points related to the roles of mutual support and advocacy.

1. The functions of mutual support and recovery advocacy should be kept separate. While advocacy may have certain therapeutic benefits, it is not a program of personal recovery and should not be thought of as a substitute for such a program.

2. When one is a member of a mutual support group and a member of a recovery advocacy organization like CCAR, these roles should be kept separate. Recovery advocacy activities should not spill into one's mutual support activities, and one's advocacy activities should be done as an individual and not as a representative of a mutual support group.

3. The anonymity tradition of Twelve Step programs should be respected in advocacy activities via no references to one's personal affiliation with a Twelve Step program at the level of television, radio or the print media.

There was a man in the audience at the first presentation I made for CCAR who as I spoke got redder, redder, and redder. Finally, he said, "You can't speak out publicly like this because of the anonymity tradition." But there was another younger man

who explained that you could disclose your recovery status and story as long as you didn't identify yourself as a member or attempt to speak on behalf of A.A. or other Twelve Step programs. It triggered a very lively discussion. Some said CCAR would never grow because of this issue of anonymity, and yet we grew because there were and are people willing to put a real face on recovery.

4. Not everyone is cut out to do recovery advocacy at a public level. Many people may have personal or family circumstances that preclude such activity. Recovery advocacy organizations like CCAR, and the larger new recovery advocacy movement, are not asking all individuals and families in recovery to step into public view, but they are calling upon a vanguard of recovering people and their families to take such action.

Family members in our focus groups talked a lot of how to separate and balance their personal needs and their advocacy activity. The following response is typical.

Family members need to understand that at times one's own needs come first. Even if you have been involved in advocacy work at one point, you may need to move in and out of advocacy work depending on how balanced your life is. This moving in and out of advocacy work is OK. Ultimately, the decision to do public advocacy with your own story comes down to what you need to do and how to minimize that impact on others close to you. At CCAR, we try to have this conversation about the risks involved in advocacy before people get extensively involved.

Members of our family focus groups did feel that family members had a unique contribution to make in the advocacy arena.

Our personal stories have not been heard in our communities. They are stories that can influence other family members and policy makers. The family experience adds to the total story of addiction and puts a positive face on recovery. They help deal with the part of the stigma that is uniquely experienced by the family member. They help members in direct recovery have a better understanding of the impact they had on family members and how to deal with those issues in respect to their own recovery. And they help their own personal recovery by giving back.

5. Involving family members in recovery advocacy provides a venue to address policy issues and conditions that are most paramount to family members. When asked for examples of such issues, focus group members most frequently noted the following:

- Exploration of the impact of stigma on family members and the need for programs that reduce such stigma at the local and national levels
- Assistance and support in talking about addiction and recovery even within one's own extended family
- Availability of treatment and recovery support resources (There were nightmarish stories about families in crisis encountering waiting lists and various procedural barriers to getting help.)
- Assistance in navigating a complex and often fragmented treatment system
- Availability of information on the relative quality of treatment agencies
- Inclusion of family members in addiction treatment (Focus group members lamented the loss of family programs as an integral component of addiction treatment.)
- Access to information about the presence of their family member in treatment (Focus group members noted that confidentiality regulations designed to protect the individual often harm the family by denying them information, not about the details of

treatment, but the presence or absence of their family member in treatment.)

Focus group members felt very strongly that community education that focused on the family experience of addiction and recovery would have diminished their own difficulties with these experiences. Such education would have given them more information and would have also created more informed and supportive social networks. Without such education, family members must either be silent or try to answer questions such as:

- How did he/she become addicted?
- Why doesn't he/she just stop?
- Why do you continue to go to those support meetings if he/she is no longer drinking?

For many family members, silence is easier than struggling to formulate answers to such questions.

Focus group members also felt cheated that they had been denied knowledge about addiction and its impact on the family. The wounds to their families not only from addiction, but also from the ignorance and stigma that surrounded it. Those wounds were also created by a lack of knowledge about what the family could expect within the recovery process. Focus group members spoke with great animation about what they did not understand about the family recovery process.

> *There is so much we don't understand about the problems of recovering families. My wife has a black belt in Al-Anon and we seem to have competing programs. We have what amounts to an ongoing angersarial relationship when it comes to programs and I don't know why. I think I've encountered more stigma inside my family than outside, and that stigma is the source of a lot of beefs that plague my marriage and my family.*

The Blessings of Advocacy

The other theme that resounded within the focus groups was the personal benefits that members had experienced from their advocacy activities.

> *Today, I am a messenger of family recovery. Somehow my experience of family recovery came up in a recent job interview. The woman who was interviewing me said, "I have a daughter who is addicted, and I don't know where to go." After she talked for some time, we both had the feeling that fate had brought us together to have this conversation.*
>
> *By speaking out, we have helped reduce the stigma that families experience as a result of having a family member addicted to alcohol and other drugs. By giving back, we have sped the progress of our own recovery. We have learned things and felt a sense of purpose that has helped us in dealing with other aspects of their life. We have helped shape policies and legislation. We have honored our family members in recovery and the family members we lost to addiction.*
>
> *I know there is power in the individual person in recovery telling his or her story publicly, but the power of the family member telling their story is potentially far greater in terms of system change. This is because of the magnitude of people in this culture who have been touched by addiction. Having the opportunity to turn our wounds into that kind of potential influence is a true gift.*

The Future of Family Members as Advocates

For two centuries, families have been as likely to be blamed for the addiction of one of their members as offered support in responding to that addiction and its impact

on themselves. And yet through this period family members have played an important role in advocating for more enlightened attitudes and social policies related to alcohol and other drug-related problems. As a new recovery advocacy movement seeks to define itself locally and nationally, we believe that is it time to honor the historical legacy of family members by embracing them as co-leaders of this movement. It is also time to define the family as the basic unit in the design of addiction treatment and sustained recovery support services.

One of CCAR's primary purposes is to put a positive face on the Recovery Community, which includes persons in direct recovery, family members and friends. A second and equally important purpose is to provide support to the recovery community to help sustain recovery and improve the quality of life for recovering people. Over the past few years, CCAR has devoted a considerable amount of work in these two areas and has started to see positive changes at the legislative, state policy and local community levels. A similar effort needs to be launched for families who have family members who are or were addicted. A vanguard of family members is needed to tell their story to legislators, policy makers, other family members and the community at large. Family members are needed to advocate for the support they need and for other family members still needing help. Telling their story will help provide a better understanding of the impact that addictions has on the family, help give permission for all families to speak about these issues, and help make it more acceptable for families to seek help for an addicted family member.

Recovery community organizations like CCAR provide training and the opportunity for family members to come together as a group to achieve things that could not be done on their own. Working as a group to put a positive face on family issues and provide support to families can provide a sense of community and purpose and provide a venue for service to other family members still suffering. To the family members who are reading this, we encourage you to seek out recovery advocacy organizations in your area and help support them in ways that will benefit you and the larger community. It is time family members became full partners in this new recovery advocacy movement.

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Citation: White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, 23(4), 3-37. Posted at **www.williamwhitepapers.com**

All in the Family: Alcohol and other Drug Problems, Recovery, Advocacy

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Abstract

Families are intimately involved in the dynamics of the alcohol/other drug problems of family members with these problems. Their adaptations to a baffling and devastating disorder of loved ones are viewed as normal and not in terms of psychopathology. Recovery resources for family members are examined, together with the need for advocacy in the part of families, expressed in the new recovery advocacy movement.

Keywords. Alcohol/other drug problems, families, recovery, advocacy

INTRODUCTION

Family members impacted by alcohol and other drug problems have been long-cursed by social stigma, public neglect, and professional misunderstanding. Parents, spouses, and children of the addicted have hidden their most life-shaping experiences behind a veil of silence and secrecy. The personal stories that they eventually shared with professionals were all too often interpreted in terms of personal psychopathology, rather than normal adaptations to a disorder both baffling and devastating. Throughout the history of addiction in America, family members have been castigated more as causative agents and sources of recovery sabotage than as recovery resources or individuals deserving services in their own right.

Given this history, it is not surprising that family members have most often found healing and purpose when they banded together for their own mutual support and political advocacy. In this two-part essay, we will first explore the history of family perspectives on addiction and recovery through the published work of psychiatrists, psychologists, social workers and addiction

counselors. We will then report the results of focus groups held in Connecticut, New York and Massachusetts with family members impacted by addiction. We close this paper with a discussion of the roles family members are playing in the new recovery advocacy movement.

PART I
HISTORICAL PERSPECTIVES ON FAMILY ADDICTION, TREATMENT, RECOVERY, and ADVOCACY

The American Temperance Movement

America's earliest recognition of chronic drunkenness as a disease was accompanied by recognition of the family as a vessel through which alcohol addiction could be transmitted across generations. In 1835, Robert MacNish set forth this emerging view in his book, *Anatomy of Drunkenness:*

> *Drunkenness appears to be in some measure hereditary. We frequently see it descending from parents to their children. This may undoubtedly often arise from bad example and imitation, but there can be little question that, in many instances, it exists as a family predisposition.* (p.61)

The belief that alcoholism was a product of heredity and parental example grew throughout the nineteenth century and added fuel to a rising eugenics movement that called for the mandatory sterilization of alcoholics and addicts (in addition to the mentally ill and developmentally disabled). The passage of these laws was based on the belief that social problems such as alcoholism were a product of bad breeding and could be eliminated by weeding degenerate families from the culture.

The American Temperance Movement was filled with graphic images of the impact of alcoholism on the family. Reformed drunkards filled temperance pulpits, sharing wrenching stories of the pain and havoc they had wreaked on their families. Temperance plays such as *The Drunkard, One Cup More,* and *The Doom of the Drunkard* portrayed the alcohol-related violence, the economic hardship, and abandonment. Women and children played important roles in the Temperance Movement. Bordin (1990), in her study of Woman's Christian Temperance Union membership, noted that many women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Local temperance society meetings served as therapeutic functions for the daughters, sisters, wives and mothers of alcoholics, and provided a vehicle through which personal pain could be transformed into political advocacy. Beginning with the founding of the Martha Washington Society in 1842, America's early recovery mutual aid societies created auxiliary societies for wives and created junior auxiliaries for children. The "Women's Crusade" and "Children's Crusade" of the 1870s and 1880s brought an unprecedented number of family members into leadership roles in rescue work with alcoholics and the drive for legal prohibition of alcohol.

The Inebriate Asylum Era

Nineteenth- and early 20th-century inebriety literature expressed enormous ambivalence toward the family of the alcoholic and addict. Wives of patients often took up temporary residence in the city nearest the inebriate asylums, so they could provide daily support to their husbands (An Inmate…1869). Wives were viewed as "loyal angels" by the patients, but inebriate asylum staff viewed family members quite differently. While acknowledging the family's role in legally committing the inebriate, taking guardianship of the inebriate's financial affairs, and visiting and supporting the inebriate in treatment; many early treatment professionals saw family

members as hostile interlopers. For example, Palmer, in his 1898 treatise *Inebriety*, had the following to say about wives:

> *The universality of good wives to intemperate husbands suggests an inquiry into the connection they may bear and the influence they may exercise, however innocently, in the downfall of their husbands.* (p. 42)

Nine years later, Cutten in his 1907 *Psychology of Alcoholism* text wrote:

> *The kindest wife and most indulgent parents are very much in the way of numerous cures, and prove to be, instead of the best friends, the worst enemies the alcoholic has.* (p. 325)

Dr. H. H. Kane noted in 1881 that many failed attempts at addiction recovery were due to what today would later be christened family enabling:

> *Very often the relatives, not understanding the meaning of certain symptoms, distressed beyond measure by the pitiful pleadings of the sufferer, will interpose and at once put an end to treatment, thus unwittingly and with well-meaning doing the patient injury of the gravest kind.* (p. 116)

As we will see, there was a thin line between saying that the family could be an obstacle to recovery and saying that the family was a cause of addiction.

Another emerging theme in the nineteenth century is the financial exploitation of family members' anguish and guilt. This was most blatant among the purveyors of bottled and boxed addiction cures, whose advertisements often targeted wives and family members. The most insidious of these claimed that alcoholics could be cured without their voluntary cooperation and, in fact, without their knowledge. Instructions that came with Formula A, for example, directed that 15 to 20 drops of Formula A be surreptitiously placed within the drinker's first drink of the day, and that if this did not induce vomiting, another 15-20 drops were to be added to the second or third drink. These were to be supplemented by sprinkling the contents of Formula A capsules in the drinker's food. Formula A, like many such cures, contained a nauseant-usually fluid extract of ipecac (American Medical Association Health Fraud and Alternative Medicine Collection, Report from Post Office Department, p.3, Box 0030-10). Among the alcoholism-cure products promoted to be secretly administered by family members included the White Star Secret Liquor Cure, The Boston Drug Cure for Drunkenness, Vantox, and Texcum Powders (Helfand, 1996).

There is very little nineteenth-century literature on the impact of addictions other than alcoholism on the family. Most narcotics addicts of this era were white, middle-aged, affluent women whose addictions and their effects on the family were virtually invisible until revealed in occasional literary works, e.g., Eugene O'Neil's autobiographical depiction of his mother's addiction in *Long Day's Journey into Night.*

The Pre-A.A./Al-Anon Years

The opening decades of the twentieth century witnessed the increased influence of psychology and psychiatry upon perceptions of the alcoholic and his/her family. Lay therapy models of alcoholism counseling birthed within the Emmanuel Clinic in Boston dominated thinking about the alcoholic and the alcoholic family. Richard Peabody (1936), the leading lay therapist of this era, believed there were three basic causes of alcoholism: (1) inheritance of a nervous system which was not resistant to alcohol, (2) the effect of the early family environment or (3) the influence of later experiences in marriage, college or work. Peabody emphasized the parental role as a causative agent of alcoholism (his followers were more specific in blaming mothers). In this view,

maternal domination (and a shy, despondent father) led to feelings of inferiority and nervousness, which, in turn, induced alcoholism.

The pioneers of the psychological therapies for the treatment of alcoholism that emerged in the 1930s generally viewed the family of the alcoholic as a nuisance or a threat. The views of Strecker and Chambers (1938) are typical. They noted the wounded pride wives experienced as a result of successful therapy, noted wives' efforts to sabotage treatment to reassert their power and control, and complained of having to deal with the wife's "childish resentments." The goal of working with the family in their view was not engaging the family's involvement but obtaining an agreement for noninterference in the alcoholic's treatment.

Psychoanalysts of the 1930s and 1940s shared similar views. Knight (1938), for example, regularly noted the lack of cooperation with and outright sabotage of treatment by the family. Therapist vacillated between including and excluding family members from the treatment process. Some therapists also demanded abstinence from the family members (Jellinek, 1942). Moore and Gray, in a 1937 article on alcoholism, talked about the need for educating the alcoholic's family and noted: "the person with the greatest need of psychiatric treatment is the marital partner who has *not* become alcoholic" (pp. 381-388).

What is striking in the opening decades of the twentieth century is the utter silence of family members. While they are described in great clinical detail, there are few first person voices conveying their vacillation between hell and hope.

Al-Anon

Alcoholics Anonymous began as a family affair, with alcoholics and their family members attending group meetings together, but the voices of family members were heard only indirectly in these early years (the section of the book Alcoholics Anonymous, entitled "To the Wives" was written by A.A. co-founder Bill Wilson). In the 1940s, wives (and later, wives and husbands) of A.A. members began to band together for mutual support in such places as Long Beach California, Richmond Virginia, and Chicago Illinois. A close reading of early editions of the *A.A. Grapevine* reveals the considerable family activity that was underway. Family members of San Diego California A.A. members organized themselves as "Alcoholics Anonymous Associates" in May of 1946. It was there that the practice of spouses joining an A.A.-affiliated support group *before* their partners joined A.A. began. A May 1947 *Grapevine* article noted regular meetings of a Family Groups in San Pedro and Sugar Hill California. The former was noted to have held annual open meetings that were used to educated doctors, judges, and welfare workers. In July of the same year, an article noted the formation of a "Non-A.A. Group" (N.A.A) for family members in Austin Texas. A similar group, referring to itself as the "A.A. Auxiliary" (A.A.A.), was formed in Rome, Georgia in July of 1947. The founding of another "Non-A.A. Group" in Rochester New York was announced in July of 1948. The Rochester group was the first noted in the *Grapevine* to have adapted the Twelve Steps for use by the husbands and wives of alcoholics. Their first step read: "We admitted we were powerless to help the alcoholic." Formal groups of the wives of A.A. members began to spread, meeting under such other names as A.A. Helpmates, Al-Anon, Alono, and Onala (*A.A. Grapevine*, 1947-1963). The growing number of these groups and their request to be listed in the *A.A. Directory* posed a growing question about the relationship between the family groups and A.A. itself (*Living With an Alcoholic*, 1980). To recognize this growing movement and to clarify its relationship to A.A., Lois Wilson and her friend Anne B. set up a service office in 1951 to support the groups. Their announced goals were:

1. To give cooperation and understanding to the A.A. at home.
2. To live by the Twelve Steps ourselves in order to grow spiritually along with our A.A.
3. To welcome and give comfort to families of new A.A.

They chose the name Al-Anon Family Groups and began responding to information requests from family members, requests that were arriving at A.A. headquarters. In the early days, they called themselves the Clearinghouse Committee, and in 1954, they incorporated as Al-Anon Family Group Headquarters, Inc. Just prior to incorporation, Henrietta S. became Al-Anon's first General Secretary/Executive Director (*Al-Anon: Then and Now*, 1986). Responding to the need for more family-oriented literature, Lois began working on a pamphlet that, with the help of Bill Wilson and editorial assistance from Margaret D. and Ralph P., became the book, *The Al-Anon Family Groups*. The first mimeographed copy of this book made its appearance at the 1955 A.A. International Convention in St. Louis.

Al-Anon meetings and literature evolved from a focus on the alcoholic to the emotional and spiritual health of Al-Anon members. As Lois Wilson (1994) has noted:

> *I suppose the seeds of Al-Anon actually germinated when the families of early A.A. members first felt the stirrings of their own regeneration, and began to do something about it* (p. 172).

Another family milestone was the founding of Alateen in 1957, which provided a support group structure for persons 12 to 20 whose lives had been affected by alcoholism.

Al-Anon and Alateen constitute a historical milestone in their focus on the needs of the alcoholic's family members. When pondering the single most important lesson she had learned in Al-Anon, Lois Wilson later stated simply:

> *…we cannot change another human being-only ourselves. By living our own lives to the best of our ability, by loving deeply and not trying to mold another to our wishes, we can help not only ourselves but that other also.* (Wilson, 1994, p. i)

Bill Wilson wrote about the dynamics of the alcoholic marriage at length in the 1952 publication *Twelve Steps and Twelve Traditions*. Here he described how alcoholism turned the alcoholic into a "sick and irresponsible child" and the non-alcoholic spouse into a resentful mother-a method of caring that the alcoholic "alternately loves and hates." Bill went on to describe how this fixed pattern is disrupted by sobriety and how the spouse may resent that A.A. has been able to do what his or her efforts could not and that the marriage in early recovery is often characterized not by grateful bliss but by blame and strain (Twelve Steps and Twelve Traditions, 1981). What Al-Anon provided was guidance through this reconstruction of intimate relationships in the transition from alcoholism to recovery.

While Al-Anon introduced family perspectives that would later exert significant influence on the treatment of alcoholism, family perspectives on and involvement in narcotic addiction treatment during the middle-twentieth century were plagued by problems of distance. Those addicts treated at Lexington and Ft. Worth, the two federal public health hospitals that opened in the 1930s, came from all over the United States. The lack of community-based treatment resources meant that family members were rarely involved in the treatment process. There is a striking absence of family perspective in the addiction literature during this era. References to family in the literature are drawn primarily from addict self-report of his/her family circumstances.

Family Advocacy and the Modern Alcoholism Movement

In 1944, Marty Mann, the first woman to achieve sustained sobriety in A.A., founded the National Committee for Education on Alcoholism (Mann, 1944). Mann's goal was nothing short of changing how America viewed alcoholism and the alcoholic. To achieve that goal, Mann organized local affiliates across the country who provided alcoholism-related information and education, worked to open hospital doors for detoxification, and encouraged the development of alcoholism treatment and convalescent centers. Family members impacted by alcoholism and blessed by recovery played important roles in this advocacy movement that laid the foundation of modern addiction treatment.

Understanding the Alcoholic Family as a System (1950s and 1960s)

Family perspectives in the 1950s shifted from looking at the alcoholic and the alcoholic spouse as individuals to looking at the alcoholic couple as a dynamic system. The focus on the alcoholic wife had shifted to a focus on the alcoholic marriage. Of particular interest was the process through which the male alcoholic and his wife struck an "interpersonal bargain" to get personal needs met and maintain some degree of homeostasis in the face of alcohol's assault on the marital relationship. A milestone in this shifting view was the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism" in the *Quarterly Journal of Studies on Alcohol*. Jackson went on to study how alcoholism elicited a wide variety of developmental problems in children of alcoholics (Jackson, 1964). The growing interest in family dynamics during the 1950s and 1960s was evident in the publication of new educational materials such as *Alcoholism: A Family Illness* (a Smithers Foundation publication) and new Al-Anon pamphlets such as *The Stag Line, What's Next? Asks the Husband of an Alcoholic, My Wife is an Alcoholic,* and *Al-Anon IS for Men* that recognized the needs of men married to alcoholic women.

The focus of family studies evolved through several stages: the alcoholic wife, the alcoholic marriage, concurrent group therapy of alcoholics and their wives, multiple couple and multiple-family group therapy approaches, concurrent inpatient/residential treatment of the alcoholic and the alcoholic spouse, and speculations on the nature of the alcoholic family as a dynamic system. What came out of these studies was the concept of "co-alcoholism"-the extension of the disease process to those people, particularly the spouse, who were most intimately involved with the alcoholic.

There are two underlying themes that permeate family studies of addiction in the 1950s and 1960s. The first are studies that document the adaptations that occur within the family in response to addiction and the addiction-related deterioration in role performance of a family member. The second is a suggestion that the marital or family environment is actually an agent in initiating and sustaining addiction. The former studies depict members as innocent victims; the latter depict family members and particularly the wife of the male alcoholic as an "etiological agent" or a factor "complicating the illness." Jackson (1962), and more recently Chaudron and Wilkinson (1988), have reviewed professional literature that not-so-subtly implied that the pathology of alcoholism was rooted not in the alcoholic man, but in his wife. (This literature was strangely silent on the husbands of alcoholic women.)

Alcoholics' wives were increasingly depicted as having chosen alcoholics in order to meet their own dependency needs. Two separately authored articles illustrate this view. In the first article, Thelma Whalen (1944, pp.632-641) described the wives of alcoholics she counseled at a family service agency in Dallas Texas. She noted that "the wife of the alcoholic has as poorly integrated a personality as her husband" and that the wife, as surely as the alcoholic, was responsible for creating the marriage and the "sordid sequence of marital misery" that

followed. Whalen describe alcoholics' wives as falling into one of four styles: (1) Suffering Susan, whose marriage and loyalty to the alcoholic was related to her need for self-punishment, (2) Controlling Catherine, who chose the alcoholic because of his inferiority and her own need to dominate, (3) Wavering Winnifred, who stayed with her alcoholic husband out of her need to be needed, and (4) Punishing Polly, whose relationship with her alcoholic husband was comparable to that of a "boa constrictor to a rabbit."

In the second article, Samuel Futterman (1953) described the prototypical wife of an alcoholic as an inadequate woman who gains ego strength only in relationship to her husband's weakness. Futterman accused the alcoholic's wife of maintaining her "illusion of indispensability" at her husband's expense by inciting his drinking episodes. He noted that it was only through such behavior that the wife could escape the depression she experienced during the periods in which her husband was sober and adequately functioning.

The general profile of the alcoholic wife depicted in this early literature was that of a woman who was neurotic, sexually repressed, dependent, man-hating, domineering, mothering, guilty and masochistic, and/or hostile and nagging (Day, 1961). The typical therapist's view of the wife of the alcoholic was generally one of "I'd drink, too, if I were married to her" (Reddy, 1971, p.1).

Al-Anon not only provided a sustained source of support to family members affected by alcoholism, but also brought together in one place a large enough pool of alcoholic wives to allow researchers to begin to test some of their propositions regarding these women's supposed pathology. By the early 1960s, objective studies began to call into question the 1950s portrayal of the alcoholic wife as having selected and remained with her husband out of her own deep emotional disturbance (Corder, Hendricks, & Corder, 1964).

Wives were not alone in being blamed for the alcoholism of their mates. Day, in her 1961 review of the alcoholism literature also noted a body of opinion suggesting that the etiology of male alcoholism could be found in the alcoholic's family of origin, particularly within the mother-son relationship. This literature emphasized the degree to which maternal domination and overindulgence created the future alcoholic's low tolerance for pain and frustration and stifled his ability to become independent and responsible. Other contributing factors in the family included a stern, autocratic father and conflicting maternal and paternal attitudes toward drinking (Day, 1961). Marking the continuity of this tradition, parents were consistently blamed as their children began illicit experimentation in the 1960s. It was in this context of blame that family therapy emerged as a primary mode of treatment for adolescent substance use disorders (Edwards & Steinglass, 1995; Liddle & Dakof, 1995).

"Family Programs" (1950s-1970s)

Most significant in the 1950s and 1960s were the emergence of explicitly family-oriented alcoholism treatment models, such as the outpatient counseling approach developed at Johns Hopkins Hospital that utilized parallel group therapy processes for alcoholics and their wives. One of the earliest family-oriented inpatient treatment approaches was initiated in 1965 at the Sandstone Hospital in Minnesota. Dr. Charles Cooper created a "Family-In" program in which families of alcoholic patients came to Sandstone for two to three days of residential, family-focused treatment (Richeson, 1978). Two other programs, Lutheran General Hospital in Illinois and Hazelden in Minnesota also experimented with residential "family week" and "family weekend" programs in the 1960s.

At Lutheran General, the original goal was to have family members live in apartments above Lutheran General's Alcoholism Treatment Center (ATC) so that they could fully participate in treatment, but these plans were abandoned when insurance companies refused to pay for the extra expense that was incurred. In spite of this setback, efforts to increase family involvement in treatment at Lutheran

General continued through the early years. An early "family night" program consisted of a lecture/discussion group. In 1978, a half-day Saturday program using Al-Anon volunteers was added, and in 1979 a formal Family Treatment Program was implemented, consisting of a three-day off-site residential retreat. Later iterations included a residential weekend model. Lutheran General's response to the families of alcoholics had two phases. The first phase was to seek family involvement because of the ways in which family members could enrich the alcoholic's treatment experience. The second phase, which began to emerge in the mid-1970s, was the recognition that family members needed and deserved treatment and support services in their own right.

A key source of family advocacy was the staff hired to work in the ATC who had extensive prior Al-Anon experience. The initiation of a formal alcoholism counselor-training program increased the involvement of Al-Anon members in the ATC. A.A. and Al-Anon members, many of them volunteers, enrolled in the training program and formed a pool from which new counselors could be hired. As the number of people with Al-Anon experience and a family-oriented perspective on alcoholism recovery increased at Lutheran General, these perspectives became integrated into Lutheran General's clinical training and public education programs.

The conceptualization of addiction as a "family disease" opened the door to exploring how this disease altered family structure (roles and subsystem interactions), family rules, family rituals, and the family's boundary transactions with the outside world. Studies of how alcoholism disrupted family rituals (e.g., meals and holidays) concluded that the disruption of such rituals increased the likelihood of intergenerational transmission of alcoholism (Wolin, Bennett, & Noonan, 1979).

The popularization of transactional analysis (TA) theory and techniques in the 1970s again shifted the focus from the effects of alcoholism on the family to the role of the family in the etiology of alcoholism. Within in the TA framework, alcoholism is the product of disordered family and social communication. Steiner (1971) posited three alcoholic roles or games: "Drunk and Proud," "Lush," and "Wino." Each of these games, as described by Steiner, involved manipulating others into the roles of persecutor, patsy, connection or rescuer. The games provide a guilt-free means of expressing aggression, an avoidance of overt anger, a projection of blame, and social attention. It was Steiner's belief that such roles could be revealed and changed through the process of therapeutic self-examination.

Denial, Enabling and Family Intervention (1970s)

A major corollary of the proposition that alcoholism is a family disease was that family homeostasis was maintained through the mechanisms of denial (portrayed metaphorically as the elephant in the living room that no one acknowledges) and enabling (any actions which prevent the alcoholic from experiencing the consequences of their drinking behavior). A further corollary was that acknowledging the problem and adopting a pattern of tough love could speed up the day when the alcoholic "hit bottom" and initiated recovery. Reverend Vern Johnson felt there had to be a better way to intervene in alcoholism than to sit and wait for the alcoholic to hit bottom. He developed a technology of family intervention through which the bottom could be raised to meet the alcoholic. He pioneered the use of a loving confrontation between the alcoholic and those who cared for the alcoholic to precipitate a crisis that most often resulted in the alcoholic's entry into alcoholism treatment. This concept was spread through a charitable foundation (the Johnson Institute) and through Johnson's publications, e.g., *I'll Quit Tomorrow* (1973/1980), which sold more than 100,000 copies.

The Family/Children of Alcoholics and the Codependency Movement (1980s)

Two overlapping movements emerged in the 1980s. The first focused on the special needs of children of alcoholics- an exploration that led to the concept of "co-alcoholism" or "para-alcoholism" (Greenleaf, 1981). During the early to middle 1980s, the work of Claudia Black and Sharon Wegscheider-Cruse graphically depicted the psychological and developmental consequences of parental alcoholism on children and catalogued how these consequences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). This marked a significant shift, in which the alcoholic's family members were viewed, not simply as sources of support for the alcoholic's recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields-counseling children and adult children of alcoholics- and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACOA) groups were formed within Al-Anon-some 1,100 by 1986-and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995).

As this movement took off, the extension of these findings to children and adult children who had been raised in other types of dysfunctional families marked a transition between the concept of co-alcoholism and the newly emerging concept of "codependence." The writings of Karen Horney, Erich Fromm, and other psychologists were used to create the concept of codependency (Melody, Miller & Miller, 1989). Dr. Timmen Cermak (1986a, b) conceptualized codependency as a "disease," proposed criteria for its medical diagnosis, and advocated that the major insurance carriers reimburse treatment of this disease. Addiction treatment programs began offering codependency treatment tracks and extending stays of alcoholics and addicts in treatment because of their "ACOA issues" or "codependency issues." Melodie Beattie launched a veritable social phenomenon with the 1987 publication of her book *Codependent No More.* She later defined five "core symptoms" of codependency: (1) difficulty experiencing appropriate levels of self-esteem, (2) difficulty setting functional boundaries, (3) difficulty owning our own reality, (4) difficulty acknowledging and meeting our own needs and wants, and (5) difficulty experiencing and expressing our reality moderately (Melody, Miller and Miller, 1989). Adding fuel to this movement was the publication the following year of John Bradshaw's *Healing the Shame That Binds You* and his highly popular PBS television series that was based on the book. A whole nation seemed to be riveted on the exploration of the "dysfunctional family" and on the extension of this concept to the workplace, and to society as a whole. This new movement also spawned its own Twelve-Step adaptation, Co-Dependents Anonymous, which by 1990 had more than 1,600 registered groups (Makela, Arminen, Bloomfield, Eisenbach-Strangl, Bergmark, Kurube and others, 1996).

The ACOA and codependency movements left many legacies. For the first time, children and adult children of alcoholics were admitted as primary patients and given a primary diagnosis as well as their own individualized treatment. These movements gave many people a heightened understanding of their own family-of-origin experiences. If there is a clear legacy from the ACOA movement it is the experiential understanding that childhood trauma can unfold developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors. The codependency movement did bear unanticipated fruit via an ideological and financial backlash that hurt the movement itself and the broader addiction treatment community from which it had been spawned.

The Codependency Backlash (1990-1995)

The backlash against the concept of codependency and its commercialized applications came from many quarters (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992). The most strident criticisms included the following:

- The definitions of codependency are so inclusive as to lack any clinical utility.
- The symptoms of codependency inordinately target women have been raised to cultivate; codependency turns social pathology into psychopathology. Energy is turned toward inner healing rather than political activism and environmental change.
- By defining the problem of "women who love too much" as one of psychopathology, we fail to hold abusive men accountable for their neglectful, demeaning and violent behavior.
- The movement sets up a milieu in which women bond out of their weakness rather than their strength (Kasl, 1992).
- The movement infantilizes its members as "Adult Children" and traps them at an immature stage of development.

In the end, it was not philosophical debate but economics that doomed the codependency movement. An aggressive system of managed behavioral health care led to a rapid erosion of first the length of treatment and then an erosion of the number of private and hospital-based addiction treatment programs. In that change, many family programs disappeared. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that it would be financial suicide to provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions.

Family Recovery Research: The New Frontier (Late 1980s-1990s)

Since 1989, Drs. Stephanie Brown and Virginia Lewis have worked to construct the developmental stages of family recovery from addiction. Their preliminary findings challenge the prevailing expectation that families can rapidly move toward health with the initiation of alcoholism recovery. They found in their research that the emotional turbulence within the family produced by addiction continues well into the first three to five years of recovery. Family recovery begins with what are, in essence, individual recoveries of its members. Without "holding environments" to sustain these individual recoveries until couple and family relationships can be reconstructed, the risk of collapse and disintegration of the family is quite high. Children older than twelve may have great difficulty participating in this family-making at a time they are moving toward individuation and separation from the family. A major implication of this research is the notion that children and families go through a "trauma of recovery"-a readjustment of expectations required by their continued psychological isolation from the addicted parent going through early recovery (Brown, 1994). Continued research on families in recovery is likely to reveal the diversity of family addiction and recovery experiences. The response of families to alcoholism and other addictive diseases is not a homogenous one that can be depicted in a single reductionist model. The diversity of family life is as wonderful in its capacity for resilience as it is sometimes horrifying in its capacity for cruelty. Each family must be its own model. Intervention into families must by characterized by gentleness and humility rather than by clinical arrogance born of knowing THE truth about the impact of addiction and recovery on the family.

Evolution of Family-Oriented Treatment

Family treatment evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, groups for wives of alcoholics, conjoint marital therapy, residential or outpatient family education, and primary treatment for family members that focused on their individual recovery. Another nuance that emerged in family programming in addiction treatment programs in the past 20 years was the effort to break intergenerational patterns of alcohol- and other drug-related problems. These efforts, particularly those that emerged in programs designed to treat addicted women with histories of child neglect and child abuse, began with simultaneous but separate interventions with addicted mothers and their children, then focused attention on enhancing the health of the family as a unit. Combining treatment services for parents and children, parenting training, and family therapy, they sought to decrease the likelihood that the children of today's clients would recapitulate these problems as they moved into their own adolescence and adulthood (White, Woll, & Webber, in press).

PART II
FAMILIES AND THE NEW RECOVERY ADVOCACY MOVEMENT

The 1980s and 1990s witnessed significant changes in the cultural perception of people with severe and persistent alcohol and other drug problems. Such problems were re-stigmatized (positive images of addiction and recovery, e.g., First Lady Betty Ford, were replaced by images that evoked fear and pessimism), demedicalized (redefined as moral problems rather than medical problems), and recriminalized (persons with these problems were transferred from systems of compassion and care to systems of control and punishment). In response to these new changes, grassroots recovery advocacy organizations began to again organize to change how America viewed addiction and those addicted. The strength of this movement, which is led by people in addiction recovery and their family members, continues to reside in its work in local communities, although efforts to forge a national-level movement are underway.

The Experience of Family Members as Advocates

To develop a better understanding of the role of family members in this new recovery advocacy movement, the authors conducted and analyzed the results of five focus group meetings of individuals whose families had been impacted by addiction and/or recovery. The meetings were hosted by the Connecticut Community for Addiction Recovery. The focus groups were conducted in the communities of Hartford, CT, Wethersfield, CT, New Haven, CT, Springfield, MA, New City, NY between the summer of 2002 and the spring of 2003. A total of 56 family members participated in the focus groups. Each focus group lasted approximately 2 hours. The members of each focus group were asked to respond to the same set of questions related to family experiences with addiction, recovery and recovery advocacy.

In the remainder of this paper, we will explore the experiences of family advocates in this new movement and end with a discussion of the future of family members as recovery advocates.

The Lived Experience of Stigma

Focus group members often opened with accounts of what it was like to live with the shame and stigma of addiction. Most striking in these accounts were repeated references to the silences that pervaded their lives-silences that grew out of a larger cultural silence about addiction.

> *I grew up in a small, French Canadian town in Northern Maine. There were and are so many alcoholics. Everybody knew our family and our situation (alcoholism), but yet nobody talked about it.*

We were very good at keeping the secret (alcoholism). There was the shame and it was very powerful.

For some this shame was magnified by cultural stereotypes of who was and was not supposed to have alcohol and drug problems.

The problem wasn't alcohol; it was crack cocaine. Where we lived this was viewed as a problem of the intercity ghetto. When our own college-educated son in the suburbs developed this problem, it was really hard to talk to others about it. This was not something our family and friends could see happening in their world. It was our shameful secret.

Such cultural silence made it very difficult for family members to come to grips with the reality of what was happening within their own families.

I thought, "My son can't be a heroin addict." When he went through treatment the first time, I thought, "Now he's fine." After treatment, I thought, "Okay, now we can all go back to normal." I didn't have a clue. I thought my son had a little problem-a little problem that went on to kill him.

My son made something very clear to me some time before he died. I had always thought of junkies as these depraved guys on the streets, and my son said to me one day, "Mom I am that junky. Don't you understand that there isn't a difference between me and that guy?" That's when it really hit me! Today when I see some poor person strung out on the street, I remind myself that this lost soul has a family like mine somewhere. It is sad that people don't understand this.

People would come to my house and see my son's picture, my son that passed away, and they couldn't believe it when I told them that he died last year of a drug overdose. They couldn't believe that he was a normal boy who went fishing and grew up to have two children and a loving family. People think of junkies as people who don't have families that care about them. What no one understands is that these junkies are our sons and daughters and brothers and sisters.

The shame attached to female addiction was greater than that for males.

Maybe this gender thing is old fashioned, but for my mother, it was so much more treacherous for her. She only went to women's meetings. A lot of people knew because when things were bad with her, it wasn't the kind of thing you could hide. But there still wasn't the same kind of openness you see with male family members in recovery.

I am proud of my father's addiction and recovery, but I have had a hard time discussing my mother's addiction and recovery, and my sister's addiction-related death.

There were also differences noted between family experience and disclosure of that experience based on whether the addicted family member was in recovery or still using.

There is a big difference between talking about a family member in recovery and one who's active. When my sister was actively using, the shame was overwhelming. I didn't really want to get into it at all. Once there is the success of recovery, it is a whole lot easier. Then you feel you can share in the pride and success of recovery. But when it's going on, it's very hard. With all the things that addicts do, even with people who are close to you, you don't want to disclose the gory details.

It was often in encounters with professional helpers that family members had to first confront the reality of addiction within their families. Yet focus group members repeatedly talked about the shame they were made to experience within these same institutions.

> *You feel dirty when you're standing in the emergency room and your child is there for a drug overdose.*

> *Interacting with some professionals is like a belly punch. One of them said to me, "I know what to do with addicts: you should put them on an island like Alcatraz and drop food and guns to let them take care of themselves." He said this in front of me. I just wanted to go into another room and cry.*

> *If someone had died in a car accident, they would take the arriving family members to a room and talk to them in a comforting way. When we arrived after being told my son had died of an overdose, they said you better hurry and say your good-byes because the Medical Examiner is coming to pick up his body at midnight. It was like he was nothing-my 24-year-old baby. Nobody walked me in. Nobody got my mother a chair. There was no social worker. They didn't ask if they could call a priest. They didn't ask what funeral home we wanted contacted. Nobody was there to help. There was no privacy-we were out in the middle of the lobby. Nobody took us into a private room. There was nothing.*

One focus group member noted that procedures designed to protect those who are addicted even reflects this stigma.

> *Sometimes I get so angry at the system. One of the things that I think is so detrimental is that the professionals can't tell me whether my daughter is in treatment or not. You don't have to tell me personal information that she has disclosed; I just want to know that she is there and is okay. I don't know where she is. She may be dead on the street. I've been concerned for 6 or 7 days. There is no other medical condition in which family members are so shut out and deprived of information. This is the only disease that even professionals can't talk about. I hope the removal of stigma will make it easier for those in my situation to get information about the status of our family member.*

During such interactions, family members reported hearing more therapeutic pessimism than hope.

> *A number of professionals that know my daughter and about her addiction have told me that she is hardcore and that she will never recover. I can't say I don't believe them, but I refuse to believe them.*

Toward Family-Inclusive Recovery Language

People recovering from addiction have evolved a language (e.g., recovering/recovered) and rituals (e.g., sobriety birthdays) to describe and celebrate their experience. Language and rituals for family members is much less defined. Some refer to themselves as "families in recovery" or a "family member in recovery," even though some focus group members felt such terms were ambiguous and confusing.

> *The term recovery is so broad it is hard to get handle on what we mean by it. The term doesn't capture the diversity of ways families experience addiction and the ways family members restore their own disordered health. I wish we could come up with a better term.*

> *I think my family members would be offended if they were known as a "family in recovery." It has a pejorative connotation.*

We could refer to ourselves as survivors of a family member's addiction or perhaps we could all wear a nametag that says "Caution: Family in Renovation."

Other family members found it difficult to apply the term when their loved one was still actively using.

The only time I'm in recovery is when my daughter is in rehab. That's because I sleep well and I know that she's being taken care of and doing something.

In the end, most focus group members felt comfortable with the term recovery but also felt family members should be able to select the term that best depicts their experience. They clearly see themselves as being in recovery, and they can pinpoint or approximate when they started on the road to recovery. They are interested in being equal partners with their formerly addicted loved ones in a recovery process and feel that use of recovery as a term for their experience enhanced understanding and acceptance by those in direct recovery from addiction. For some family members, the term recovery implies a retrieval of what was lost through addiction (e.g., trust, economic security, intimacy, laughter). For others, such as those whose family member died an addiction-related death, the term recovery implies the long process of grieving and healing.

Persons recovering from addiction use the date that they stopped drug use as their point of recovery initiation and often celebrate that date similar to a birthday. Family members have much greater difficulty pinpointing the initiation of their own recovery process. Some use the recovery initiation date of their family member while others note a particular milestone in their own healing or growth.

It's a long time before you believe it's for real. My father used to celebrate his sobriety anniversary with coins and all that stuff, but it wasn't until he got 7 or 8 years in that we started to believe it. I am not sure I can mark the date for me as a family member, but there clearly was a date when he stopped.

You could pinpoint the period when you understood and stopped enabling, but I think that process is gradual. It's hard to pick a date. It's cumulative.

Marking recovery by enabling alone would be difficult. Enabling is one of the hardest words to deal with. One day you think you're enabling and the next day you do the same thing and you're helping out.

For me events have more of an impact than a date. His last rehab was very eventful for the both of us. I saw a change in him. The return of his soul is the only way I can describe it. The new place that he was at means more to me than any date. It's a developmental process.

Another approach to defining recovery initiation for family members is to focus on the stage at which the member stopped reacting to the addicted family member and focused instead on their own needs and aspirations.

The Decision to Keep or Break Silence: Responses to the Family Addiction/Recovery Story

Family members have three levels at which silence can be broken regarding their experiences with an alcohol- or other drug-addicted family member. These levels mark the stages between personal recovery and political advocacy.

Breaking silence to others cannot occur until there is a breakthrough of insight that allows one to reconstruct the perception of the addicted family member. Many focus group members noted the importance of

such breakthroughs. What this revealed was that silence must be broken within the self before it can be broken to others.

> *I talk to myself. There was a point at somewhere maybe 15 or 20 years ago that I really started to delve into what is this alcoholic family that I grew up in? I reached a point where I accepted the fact that my father was an alcoholic, and I started to get involved in a lot of different things. There was a clear point at which how I saw him and myself started to shift. That was when I decided I wasn't going to be ashamed any more.*
>
> *You have to make sense of what happened and heal yourself before you can carry a message of hope to others. I came to realize that my son had a disease. You can forgive somebody for having cancer; why can't you forgive them for having the disease of addiction? The terrible things they do are part of their disease. My son did a lot of terrible things, but it never meant that he wasn't a good person or that he didn't love me.*

The helpfulness of these new insights opens the doorway for disclosure to others. One of the most difficult arenas for such disclosure involves other family members. The second level of silence-breaking occurs within the family itself. Even some of the most articulate advocates-persons who have championed recovery in all manner of public forums-confessed the difficulty they had talking with other family members about the experience with addiction. Few topics generated such lengthy and detailed responses.

> *I found it easier to talk to people outside of my family…my son is an addict, and I've never even to this day expressed those words to my family. When he was 17 and he started drinking they said it was just a stage and not to worry about it. They know he's been in rehab and on probation, but we've never discussed these things in detail. Part of the reason that I never told them about his addiction was that I felt it would change how they acted towards him and I didn't want that to happen.*
>
> *I have a problem talking about all this with certain members of my family. They have a different outlook on life. They have to shop at Bloomingdales. They just can't shop anywhere else. With certain people, you just can't go there with this subject.*
>
> *I was given an award, not too long ago, and my siblings attended. After my talk on my involvement in the recovery advocacy movement, my wife asked me why I hadn't mentioned my father's alcoholism. I didn't dare broach this subject then for fear of upsetting my siblings. I was silent because I didn't want to have my whole family teed off at me for acknowledging that my father was an alcoholic. This was fifty years of stigma and shame still influencing my behavior.*
>
> *I think we had a harder time with this because it's not a parent who is addicted but our own child. With a child, it is hard not to feel responsible. You are seen as having failed in a vital part of your life. People think that you somehow allowed your kid to become addicted. I have not shared this with some of my own siblings. I have four siblings, but have only talked about my son's addiction with one.*
>
> *The risk that I face is alienation of my siblings, especially with my sister, which is interesting since her husband died of alcoholism. Our relationship has developed in a unique way and I don't want to ruin that. Besides, protecting the alcoholic is still ingrained in me after all those*

years. When I first spoke about my father's alcoholism at a CCAR meeting, I started crying. I didn't realize I would react that way. So there is also the risk of embarrassment in the presence of one's family. My brother is coming down shortly and this obviously won't be a topic. My family knows what I'm doing but I don't push it too far.

I've talked to my mother about my advocacy work, but she's not too excited about it. I've tried to talk to all my brothers and sisters about what I'm involved in and they have provided ambivalent support for my going public with our story.

A person in our group wanted to speak publicly but her daughter was very upset and thought it was simply an airing of the family's dirty laundry in public. It took this woman almost three months to explain to her daughter and have her daughter come around to the fact that what she was doing was very important.

We have CCAR members who are active with us but will not speak publicly because their addicted family members refuse to let them do so.

Going Public

The decision to go public with one's family story of addiction or recovery is a highly personal one. Perhaps the first obstacle to overcome is the anticipation of judgments that others will make.

I think the risk that you face, is what people are going to think. When I tell them what happened to my son, they give me a look and just roll their eyes. I can see that they really don't believe me. I can hear their minds saying that my son was no good and that I must have done something wrong. I risk those judgments for the sake of my son and every other family that could face the nightmare I have lived through.

When I considered going public, all I could think of was my neighbors. I knew I would run this risk of them judging me and having them wonder what I did wrong. I wanted to be thought of as a good parent, but there were several instances when my son acted up in our neighborhood. I had to get past the thought of those people judging me.

I don't care what people think: I will tell the truth of our experience. I loved my grandson, and I hope I can help other people by telling them our story. I don't care if it's in the newspaper. It is the truth of what happened in our life. We went through a lot of pain and we're still recovering.

Most focus groups members talked about having passed through the stage of their concerns about the judgment of others to a place where the message was more important than their potential embarrassment. The first element of that message was that addiction could touch any family and the devastating impact of addiction upon the family as a whole. The second element was about the potential for recovery and the process of recovery for the individual and the family. The potential benefit of this message to others eventually outweighed concerns about personal privacy. There was also in the decision to go public a dimension of anger: anger that their pain could have been lessened if addiction had not been so shrouded in shame and silence.

Family advocacy is important due to the demoralization and anger families often experience through multiple episodes of recovery initiation and relapse. Families need to know that there are permanent solutions to addiction and that there is hope for their loved one and their family. Families telling their stories of survival, forgiveness and reconciliation are powerful antidotes to

the hopelessness that so often pervades the perception of addiction in this culture.

Parents who have lost children to addiction face a special challenge working in recovery advocacy. It is sometimes hard for these parents to work with individuals and families in sustained recovery. Through these relationships they must face the question of why their family was not included among the success stories. For our focus group members, the potential value of their stories to other parents and the larger community overcame such questioning. Most committed their work in advocacy to the loving memories of their lost children.

What family members do is shine a light on the shrouded world of addiction and recovery.

> *When family members speak out, they normalize the addiction experience. When I publicly declare, "I'm a member of a family that has been wounded by addiction," I'm saying that this problem can touch anywhere, that I'm not different than you are. What we can do as family members is try to help others understand what they are dealing with. Our job is to take some of the stigma off being a family touched by addiction and take away the guilt and shame that comes with that.*

When people openly talk about stigmatized issues and experiences to others, there is no cultural etiquette to define what is expected from those hearing this account. The inclination is for people to offer advice about how the problem can be solved.

> *If I tell you my lawn is bad and you tell me to put Scotts on four times a year and then I don't do it, you're going to be upset with me because I didn't take your advice. Sometimes we don't talk because we don't want the advice. We just want them to listen to what we are going through. We need to be honest with people and tell them we are not asking for advice. We need to tell them we have had advice from all quarters, that what we need now is a sympathetic ear and understanding.*

One of the issues that arises following the decision to put a public face and voice on the family experience of addiction and recovery is how to tell one's story as a family member without bringing embarrassment to the addicted or recovering family member.

> *Our son lives and works in the area where we live. I've always been conscious of how my public disclosures could affect him and his business. So I don't say anything unless he says it is all right, or I know he has talked about it. I feel very protective about that. He is in business for himself and he's doing very well, but it's an occupation that requires people's trust. I wouldn't want to do anything to hurt that. It is very important that you have the support of the member, if you are going to speak out, otherwise it could have an adverse effect.*
>
> *This is our son's private place and we've decided that it is not our privilege to talk about that in forums that would bring embarrassment to him. He's part of our local community and we feel we don't have the privilege to publicly tell his story here. We can support him and this movement in ways other than our story.*
>
> *The way I handle this is to not go into a lot of details about his* [addicted family member's] *experience. I try to keep the story to what I experienced.*
>
> *It's not the concerns for myself but for my children, if one of their peers finds out their dad is an alcoholic. How much do I say as a parent and where do I draw the line to keep their life private? I don't stop myself in saying*

what I have to say but I kind of watch it sometimes because of them.

I think we have to be discrete. If I'm going to disclose my story in a public forum, I'm not going to give all the details. I certainly have to take into consideration how disclosing this story will affect my family. Otherwise, I am back to being a self-centered person.

Not everyone is suited to tell their story to a local newspaper or speak before a group of legislators. The personal vulnerability of such disclosure is a reality, but many focus group members talked about how the risks of recovery advocacy were diminished when they stood with large numbers of other people in recovery.

I go to Legislative Day and to the Recovery Walks where there are hundreds or thousands of other people. Those activities are less personally vulnerable because of the sheer number of people who are there.

Some family members expressed concern about potential embarrassment brought to children within the family. The following comment underscores just how personal is the decision and timing of recovery advocacy activities.

Our children are at an age where they want to be like everyone else. They don't want to stand out in any way. So we have been careful to talk to them about when and how we tell our story at a public level. We could even reach a period where we don't tell our story publicly for a while if we decided that it would make our children too uncomfortable.

The fear of potential embarrassment is often overcome by pain, grief, anger, or gratitude.

I refuse to let my son die with that stigma over his head. If it takes to the day I die, I'm going to fight to get rid of the shame and stigma attached to addiction.

There was Al-Anon, but there was nothing there for parents who have lost their sons or daughters to addiction. That's what I committed myself to change.

The women in this group have all lost children to drug overdoses. If we don't speak out, our children will have died in vain.

Recovery Mutual Support and Recovery Advocacy

Family members made several key points related to the roles of mutual support and advocacy.

1. The functions of mutual support and recovery advocacy should be kept separate. While advocacy may have certain therapeutic benefits, it is not a program of personal recovery and should not be thought of as a substitute for such a program.

2. When one is a member of a mutual support group and a member of a recovery advocacy organization like CCAR, these roles should be kept separate. Recovery advocacy activities should not spill into one's mutual support activities, and one's advocacy activities should be done as an individual and not as a representative of a mutual support group.

3. The anonymity tradition of Twelve Step programs should be respected in advocacy activities via no references to one's personal affiliation with a Twelve Step program at the level of television, radio or the print media.

There was a man in the audience at the first presentation I made for CCAR who as I spoke got redder, redder, and redder. Finally, he said, "You can't speak out publicly like this because of the anonymity tradition." But there was another younger man

who explained that you could disclose your recovery status and story as long as you didn't identify yourself as a member or attempt to speak on behalf of A.A. or other Twelve Step programs. It triggered a very lively discussion. Some said CCAR would never grow because of this issue of anonymity, and yet we grew because there were and are people willing to put a real face on recovery.

4. Not everyone is cut out to do recovery advocacy at a public level. Many people may have personal or family circumstances that preclude such activity. Recovery advocacy organizations like CCAR, and the larger new recovery advocacy movement, are not asking all individuals and families in recovery to step into public view, but they are calling upon a vanguard of recovering people and their families to take such action.

Family members in our focus groups talked a lot of how to separate and balance their personal needs and their advocacy activity. The following response is typical.

Family members need to understand that at times one's own needs come first. Even if you have been involved in advocacy work at one point, you may need to move in and out of advocacy work depending on how balanced your life is. This moving in and out of advocacy work is OK. Ultimately, the decision to do public advocacy with your own story comes down to what you need to do and how to minimize that impact on others close to you. At CCAR, we try to have this conversation about the risks involved in advocacy before people get extensively involved.

Members of our family focus groups did feel that family members had a unique contribution to make in the advocacy arena.

Our personal stories have not been heard in our communities. They are stories that can influence other family members and policy makers. The family experience adds to the total story of addiction and puts a positive face on recovery. They help deal with the part of the stigma that is uniquely experienced by the family member. They help members in direct recovery have a better understanding of the impact they had on family members and how to deal with those issues in respect to their own recovery. And they help their own personal recovery by giving back.

5. Involving family members in recovery advocacy provides a venue to address policy issues and conditions that are most paramount to family members. When asked for examples of such issues, focus group members most frequently noted the following:

- Exploration of the impact of stigma on family members and the need for programs that reduce such stigma at the local and national levels
- Assistance and support in talking about addiction and recovery even within one's own extended family
- Availability of treatment and recovery support resources (There were nightmarish stories about families in crisis encountering waiting lists and various procedural barriers to getting help.)
- Assistance in navigating a complex and often fragmented treatment system
- Availability of information on the relative quality of treatment agencies
- Inclusion of family members in addiction treatment (Focus group members lamented the loss of family programs as an integral component of addiction treatment.)
- Access to information about the presence of their family member in treatment (Focus group members noted that confidentiality regulations designed to protect the individual often harm the family by denying them information, not about the details of

treatment, but the presence or absence of their family member in treatment.)

Focus group members felt very strongly that community education that focused on the family experience of addiction and recovery would have diminished their own difficulties with these experiences. Such education would have given them more information and would have also created more informed and supportive social networks. Without such education, family members must either be silent or try to answer questions such as:

- How did he/she become addicted?
- Why doesn't he/she just stop?
- Why do you continue to go to those support meetings if he/she is no longer drinking?

For many family members, silence is easier than struggling to formulate answers to such questions.

Focus group members also felt cheated that they had been denied knowledge about addiction and its impact on the family. The wounds to their families not only from addiction, but also from the ignorance and stigma that surrounded it. Those wounds were also created by a lack of knowledge about what the family could expect within the recovery process. Focus group members spoke with great animation about what they did not understand about the family recovery process.

> *There is so much we don't understand about the problems of recovering families. My wife has a black belt in Al-Anon and we seem to have competing programs. We have what amounts to an ongoing angersarial relationship when it comes to programs and I don't know why. I think I've encountered more stigma inside my family than outside, and that stigma is the source of a lot of beefs that plague my marriage and my family.*

The Blessings of Advocacy

The other theme that resounded within the focus groups was the personal benefits that members had experienced from their advocacy activities.

> *Today, I am a messenger of family recovery. Somehow my experience of family recovery came up in a recent job interview. The woman who was interviewing me said, "I have a daughter who is addicted, and I don't know where to go." After she talked for some time, we both had the feeling that fate had brought us together to have this conversation.*
>
> *By speaking out, we have helped reduce the stigma that families experience as a result of having a family member addicted to alcohol and other drugs. By giving back, we have sped the progress of our own recovery. We have learned things and felt a sense of purpose that has helped us in dealing with other aspects of their life. We have helped shape policies and legislation. We have honored our family members in recovery and the family members we lost to addiction.*
>
> *I know there is power in the individual person in recovery telling his or her story publicly, but the power of the family member telling their story is potentially far greater in terms of system change. This is because of the magnitude of people in this culture who have been touched by addiction. Having the opportunity to turn our wounds into that kind of potential influence is a true gift.*

The Future of Family Members as Advocates

For two centuries, families have been as likely to be blamed for the addiction of one of their members as offered support in responding to that addiction and its impact

on themselves. And yet through this period family members have played an important role in advocating for more enlightened attitudes and social policies related to alcohol and other drug-related problems. As a new recovery advocacy movement seeks to define itself locally and nationally, we believe that is it time to honor the historical legacy of family members by embracing them as co-leaders of this movement. It is also time to define the family as the basic unit in the design of addiction treatment and sustained recovery support services.

One of CCAR's primary purposes is to put a positive face on the Recovery Community, which includes persons in direct recovery, family members and friends. A second and equally important purpose is to provide support to the recovery community to help sustain recovery and improve the quality of life for recovering people. Over the past few years, CCAR has devoted a considerable amount of work in these two areas and has started to see positive changes at the legislative, state policy and local community levels. A similar effort needs to be launched for families who have family members who are or were addicted. A vanguard of family members is needed to tell their story to legislators, policy makers, other family members and the community at large. Family members are needed to advocate for the support they need and for other family members still needing help. Telling their story will help provide a better understanding of the impact that addictions has on the family, help give permission for all families to speak about these issues, and help make it more acceptable for families to seek help for an addicted family member.

Recovery community organizations like CCAR provide training and the opportunity for family members to come together as a group to achieve things that could not be done on their own. Working as a group to put a positive face on family issues and provide support to families can provide a sense of community and purpose and provide a venue for service to other family members still suffering. To the family members who are reading this, we encourage you to seek out recovery advocacy organizations in your area and help support them in ways that will benefit you and the larger community. It is time family members became full partners in this new recovery advocacy movement.

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Citation: White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, 23(4), 3-37. Posted at **www.williamwhitepapers.com**

All in the Family: Alcohol and other Drug Problems, Recovery, Advocacy

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Abstract

Families are intimately involved in the dynamics of the alcohol/other drug problems of family members with these problems. Their adaptations to a baffling and devastating disorder of loved ones are viewed as normal and not in terms of psychopathology. Recovery resources for family members are examined, together with the need for advocacy in the part of families, expressed in the new recovery advocacy movement.

Keywords. Alcohol/other drug problems, families, recovery, advocacy

INTRODUCTION

Family members impacted by alcohol and other drug problems have been long-cursed by social stigma, public neglect, and professional misunderstanding. Parents, spouses, and children of the addicted have hidden their most life-shaping experiences behind a veil of silence and secrecy. The personal stories that they eventually shared with professionals were all too often interpreted in terms of personal psychopathology, rather than normal adaptations to a disorder both baffling and devastating. Throughout the history of addiction in America, family members have been castigated more as causative agents and sources of recovery sabotage than as recovery resources or individuals deserving services in their own right.

Given this history, it is not surprising that family members have most often found healing and purpose when they banded together for their own mutual support and political advocacy. In this two-part essay, we will first explore the history of family perspectives on addiction and recovery through the published work of psychiatrists, psychologists, social workers and addiction

counselors. We will then report the results of focus groups held in Connecticut, New York and Massachusetts with family members impacted by addiction. We close this paper with a discussion of the roles family members are playing in the new recovery advocacy movement.

PART I
HISTORICAL PERSPECTIVES ON FAMILY ADDICTION, TREATMENT, RECOVERY, and ADVOCACY

The American Temperance Movement

America's earliest recognition of chronic drunkenness as a disease was accompanied by recognition of the family as a vessel through which alcohol addiction could be transmitted across generations. In 1835, Robert MacNish set forth this emerging view in his book, *Anatomy of Drunkenness:*

> *Drunkenness appears to be in some measure hereditary. We frequently see it descending from parents to their children. This may undoubtedly often arise from bad example and imitation, but there can be little question that, in many instances, it exists as a family predisposition.* (p.61)

The belief that alcoholism was a product of heredity and parental example grew throughout the nineteenth century and added fuel to a rising eugenics movement that called for the mandatory sterilization of alcoholics and addicts (in addition to the mentally ill and developmentally disabled). The passage of these laws was based on the belief that social problems such as alcoholism were a product of bad breeding and could be eliminated by weeding degenerate families from the culture.

The American Temperance Movement was filled with graphic images of the impact of alcoholism on the family. Reformed drunkards filled temperance pulpits, sharing wrenching stories of the pain and havoc they had wreaked on their families. Temperance plays such as *The Drunkard, One Cup More,* and *The Doom of the Drunkard* portrayed the alcohol-related violence, the economic hardship, and abandonment. Women and children played important roles in the Temperance Movement. Bordin (1990), in her study of Woman's Christian Temperance Union membership, noted that many women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Local temperance society meetings served as therapeutic functions for the daughters, sisters, wives and mothers of alcoholics, and provided a vehicle through which personal pain could be transformed into political advocacy. Beginning with the founding of the Martha Washington Society in 1842, America's early recovery mutual aid societies created auxiliary societies for wives and created junior auxiliaries for children. The "Women's Crusade" and "Children's Crusade" of the 1870s and 1880s brought an unprecedented number of family members into leadership roles in rescue work with alcoholics and the drive for legal prohibition of alcohol.

The Inebriate Asylum Era

Nineteenth- and early 20th-century inebriety literature expressed enormous ambivalence toward the family of the alcoholic and addict. Wives of patients often took up temporary residence in the city nearest the inebriate asylums, so they could provide daily support to their husbands (An Inmate…1869). Wives were viewed as "loyal angels" by the patients, but inebriate asylum staff viewed family members quite differently. While acknowledging the family's role in legally committing the inebriate, taking guardianship of the inebriate's financial affairs, and visiting and supporting the inebriate in treatment; many early treatment professionals saw family

members as hostile interlopers. For example, Palmer, in his 1898 treatise *Inebriety*, had the following to say about wives:

> *The universality of good wives to intemperate husbands suggests an inquiry into the connection they may bear and the influence they may exercise, however innocently, in the downfall of their husbands.* (p. 42)

Nine years later, Cutten in his 1907 *Psychology of Alcoholism* text wrote:

> *The kindest wife and most indulgent parents are very much in the way of numerous cures, and prove to be, instead of the best friends, the worst enemies the alcoholic has.* (p. 325)

Dr. H. H. Kane noted in 1881 that many failed attempts at addiction recovery were due to what today would later be christened family enabling:

> *Very often the relatives, not understanding the meaning of certain symptoms, distressed beyond measure by the pitiful pleadings of the sufferer, will interpose and at once put an end to treatment, thus unwittingly and with well-meaning doing the patient injury of the gravest kind.* (p. 116)

As we will see, there was a thin line between saying that the family could be an obstacle to recovery and saying that the family was a cause of addiction.

Another emerging theme in the nineteenth century is the financial exploitation of family members' anguish and guilt. This was most blatant among the purveyors of bottled and boxed addiction cures, whose advertisements often targeted wives and family members. The most insidious of these claimed that alcoholics could be cured without their voluntary cooperation and, in fact, without their knowledge. Instructions that came with Formula A, for example, directed that 15 to 20 drops of Formula A be surreptitiously placed within the drinker's first drink of the day, and that if this did not induce vomiting, another 15-20 drops were to be added to the second or third drink. These were to be supplemented by sprinkling the contents of Formula A capsules in the drinker's food. Formula A, like many such cures, contained a nauseant-usually fluid extract of ipecac (American Medical Association Health Fraud and Alternative Medicine Collection, Report from Post Office Department, p.3, Box 0030-10). Among the alcoholism-cure products promoted to be secretly administered by family members included the White Star Secret Liquor Cure, The Boston Drug Cure for Drunkenness, Vantox, and Texcum Powders (Helfand, 1996).

There is very little nineteenth-century literature on the impact of addictions other than alcoholism on the family. Most narcotics addicts of this era were white, middle-aged, affluent women whose addictions and their effects on the family were virtually invisible until revealed in occasional literary works, e.g., Eugene O'Neil's autobiographical depiction of his mother's addiction in *Long Day's Journey into Night.*

The Pre-A.A./Al-Anon Years

The opening decades of the twentieth century witnessed the increased influence of psychology and psychiatry upon perceptions of the alcoholic and his/her family. Lay therapy models of alcoholism counseling birthed within the Emmanuel Clinic in Boston dominated thinking about the alcoholic and the alcoholic family. Richard Peabody (1936), the leading lay therapist of this era, believed there were three basic causes of alcoholism: (1) inheritance of a nervous system which was not resistant to alcohol, (2) the effect of the early family environment or (3) the influence of later experiences in marriage, college or work. Peabody emphasized the parental role as a causative agent of alcoholism (his followers were more specific in blaming mothers). In this view,

maternal domination (and a shy, despondent father) led to feelings of inferiority and nervousness, which, in turn, induced alcoholism.

The pioneers of the psychological therapies for the treatment of alcoholism that emerged in the 1930s generally viewed the family of the alcoholic as a nuisance or a threat. The views of Strecker and Chambers (1938) are typical. They noted the wounded pride wives experienced as a result of successful therapy, noted wives' efforts to sabotage treatment to reassert their power and control, and complained of having to deal with the wife's "childish resentments." The goal of working with the family in their view was not engaging the family's involvement but obtaining an agreement for noninterference in the alcoholic's treatment.

Psychoanalysts of the 1930s and 1940s shared similar views. Knight (1938), for example, regularly noted the lack of cooperation with and outright sabotage of treatment by the family. Therapist vacillated between including and excluding family members from the treatment process. Some therapists also demanded abstinence from the family members (Jellinek, 1942). Moore and Gray, in a 1937 article on alcoholism, talked about the need for educating the alcoholic's family and noted: "the person with the greatest need of psychiatric treatment is the marital partner who has *not* become alcoholic" (pp. 381-388).

What is striking in the opening decades of the twentieth century is the utter silence of family members. While they are described in great clinical detail, there are few first person voices conveying their vacillation between hell and hope.

Al-Anon

Alcoholics Anonymous began as a family affair, with alcoholics and their family members attending group meetings together, but the voices of family members were heard only indirectly in these early years (the section of the book Alcoholics Anonymous, entitled "To the Wives" was written by A.A. co-founder Bill Wilson). In the 1940s, wives (and later, wives and husbands) of A.A. members began to band together for mutual support in such places as Long Beach California, Richmond Virginia, and Chicago Illinois. A close reading of early editions of the *A.A. Grapevine* reveals the considerable family activity that was underway. Family members of San Diego California A.A. members organized themselves as "Alcoholics Anonymous Associates" in May of 1946. It was there that the practice of spouses joining an A.A.-affiliated support group *before* their partners joined A.A. began. A May 1947 *Grapevine* article noted regular meetings of a Family Groups in San Pedro and Sugar Hill California. The former was noted to have held annual open meetings that were used to educated doctors, judges, and welfare workers. In July of the same year, an article noted the formation of a "Non-A.A. Group" (N.A.A) for family members in Austin Texas. A similar group, referring to itself as the "A.A. Auxiliary" (A.A.A.), was formed in Rome, Georgia in July of 1947. The founding of another "Non-A.A. Group" in Rochester New York was announced in July of 1948. The Rochester group was the first noted in the *Grapevine* to have adapted the Twelve Steps for use by the husbands and wives of alcoholics. Their first step read: "We admitted we were powerless to help the alcoholic." Formal groups of the wives of A.A. members began to spread, meeting under such other names as A.A. Helpmates, Al-Anon, Alono, and Onala (*A.A. Grapevine*, 1947-1963). The growing number of these groups and their request to be listed in the *A.A. Directory* posed a growing question about the relationship between the family groups and A.A. itself (*Living With an Alcoholic*, 1980). To recognize this growing movement and to clarify its relationship to A.A., Lois Wilson and her friend Anne B. set up a service office in 1951 to support the groups. Their announced goals were:

1. To give cooperation and understanding to the A.A. at home.
2. To live by the Twelve Steps ourselves in order to grow spiritually along with our A.A.
3. To welcome and give comfort to families of new A.A.

They chose the name Al-Anon Family Groups and began responding to information requests from family members, requests that were arriving at A.A. headquarters. In the early days, they called themselves the Clearinghouse Committee, and in 1954, they incorporated as Al-Anon Family Group Headquarters, Inc. Just prior to incorporation, Henrietta S. became Al-Anon's first General Secretary/Executive Director (*Al-Anon: Then and Now*, 1986). Responding to the need for more family-oriented literature, Lois began working on a pamphlet that, with the help of Bill Wilson and editorial assistance from Margaret D. and Ralph P., became the book, *The Al-Anon Family Groups*. The first mimeographed copy of this book made its appearance at the 1955 A.A. International Convention in St. Louis.

Al-Anon meetings and literature evolved from a focus on the alcoholic to the emotional and spiritual health of Al-Anon members. As Lois Wilson (1994) has noted:

> *I suppose the seeds of Al-Anon actually germinated when the families of early A.A. members first felt the stirrings of their own regeneration, and began to do something about it* (p. 172).

Another family milestone was the founding of Alateen in 1957, which provided a support group structure for persons 12 to 20 whose lives had been affected by alcoholism.

Al-Anon and Alateen constitute a historical milestone in their focus on the needs of the alcoholic's family members. When pondering the single most important lesson she had learned in Al-Anon, Lois Wilson later stated simply:

> *…we cannot change another human being-only ourselves. By living our own lives to the best of our ability, by loving deeply and not trying to mold another to our wishes, we can help not only ourselves but that other also.* (Wilson, 1994, p. i)

Bill Wilson wrote about the dynamics of the alcoholic marriage at length in the 1952 publication *Twelve Steps and Twelve Traditions*. Here he described how alcoholism turned the alcoholic into a "sick and irresponsible child" and the non-alcoholic spouse into a resentful mother-a method of caring that the alcoholic "alternately loves and hates." Bill went on to describe how this fixed pattern is disrupted by sobriety and how the spouse may resent that A.A. has been able to do what his or her efforts could not and that the marriage in early recovery is often characterized not by grateful bliss but by blame and strain (Twelve Steps and Twelve Traditions, 1981). What Al-Anon provided was guidance through this reconstruction of intimate relationships in the transition from alcoholism to recovery.

While Al-Anon introduced family perspectives that would later exert significant influence on the treatment of alcoholism, family perspectives on and involvement in narcotic addiction treatment during the middle-twentieth century were plagued by problems of distance. Those addicts treated at Lexington and Ft. Worth, the two federal public health hospitals that opened in the 1930s, came from all over the United States. The lack of community-based treatment resources meant that family members were rarely involved in the treatment process. There is a striking absence of family perspective in the addiction literature during this era. References to family in the literature are drawn primarily from addict self-report of his/her family circumstances.

Family Advocacy and the Modern Alcoholism Movement

In 1944, Marty Mann, the first woman to achieve sustained sobriety in A.A., founded the National Committee for Education on Alcoholism (Mann, 1944). Mann's goal was nothing short of changing how America viewed alcoholism and the alcoholic. To achieve that goal, Mann organized local affiliates across the country who provided alcoholism-related information and education, worked to open hospital doors for detoxification, and encouraged the development of alcoholism treatment and convalescent centers. Family members impacted by alcoholism and blessed by recovery played important roles in this advocacy movement that laid the foundation of modern addiction treatment.

Understanding the Alcoholic Family as a System (1950s and 1960s)

Family perspectives in the 1950s shifted from looking at the alcoholic and the alcoholic spouse as individuals to looking at the alcoholic couple as a dynamic system. The focus on the alcoholic wife had shifted to a focus on the alcoholic marriage. Of particular interest was the process through which the male alcoholic and his wife struck an "interpersonal bargain" to get personal needs met and maintain some degree of homeostasis in the face of alcohol's assault on the marital relationship. A milestone in this shifting view was the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism" in the *Quarterly Journal of Studies on Alcohol*. Jackson went on to study how alcoholism elicited a wide variety of developmental problems in children of alcoholics (Jackson, 1964). The growing interest in family dynamics during the 1950s and 1960s was evident in the publication of new educational materials such as *Alcoholism: A Family Illness* (a Smithers Foundation publication) and new Al-Anon pamphlets such as *The Stag Line, What's Next? Asks the Husband of an Alcoholic, My Wife is an Alcoholic,* and *Al-Anon IS for Men* that recognized the needs of men married to alcoholic women.

The focus of family studies evolved through several stages: the alcoholic wife, the alcoholic marriage, concurrent group therapy of alcoholics and their wives, multiple couple and multiple-family group therapy approaches, concurrent inpatient/residential treatment of the alcoholic and the alcoholic spouse, and speculations on the nature of the alcoholic family as a dynamic system. What came out of these studies was the concept of "co-alcoholism"-the extension of the disease process to those people, particularly the spouse, who were most intimately involved with the alcoholic.

There are two underlying themes that permeate family studies of addiction in the 1950s and 1960s. The first are studies that document the adaptations that occur within the family in response to addiction and the addiction-related deterioration in role performance of a family member. The second is a suggestion that the marital or family environment is actually an agent in initiating and sustaining addiction. The former studies depict members as innocent victims; the latter depict family members and particularly the wife of the male alcoholic as an "etiological agent" or a factor "complicating the illness." Jackson (1962), and more recently Chaudron and Wilkinson (1988), have reviewed professional literature that not-so-subtly implied that the pathology of alcoholism was rooted not in the alcoholic man, but in his wife. (This literature was strangely silent on the husbands of alcoholic women.)

Alcoholics' wives were increasingly depicted as having chosen alcoholics in order to meet their own dependency needs. Two separately authored articles illustrate this view. In the first article, Thelma Whalen (1944, pp.632-641) described the wives of alcoholics she counseled at a family service agency in Dallas Texas. She noted that "the wife of the alcoholic has as poorly integrated a personality as her husband" and that the wife, as surely as the alcoholic, was responsible for creating the marriage and the "sordid sequence of marital misery" that

followed. Whalen describe alcoholics' wives as falling into one of four styles: (1) Suffering Susan, whose marriage and loyalty to the alcoholic was related to her need for self-punishment, (2) Controlling Catherine, who chose the alcoholic because of his inferiority and her own need to dominate, (3) Wavering Winnifred, who stayed with her alcoholic husband out of her need to be needed, and (4) Punishing Polly, whose relationship with her alcoholic husband was comparable to that of a "boa constrictor to a rabbit."

In the second article, Samuel Futterman (1953) described the prototypical wife of an alcoholic as an inadequate woman who gains ego strength only in relationship to her husband's weakness. Futterman accused the alcoholic's wife of maintaining her "illusion of indispensability" at her husband's expense by inciting his drinking episodes. He noted that it was only through such behavior that the wife could escape the depression she experienced during the periods in which her husband was sober and adequately functioning.

The general profile of the alcoholic wife depicted in this early literature was that of a woman who was neurotic, sexually repressed, dependent, man-hating, domineering, mothering, guilty and masochistic, and/or hostile and nagging (Day, 1961). The typical therapist's view of the wife of the alcoholic was generally one of "I'd drink, too, if I were married to her" (Reddy, 1971, p.1).

Al-Anon not only provided a sustained source of support to family members affected by alcoholism, but also brought together in one place a large enough pool of alcoholic wives to allow researchers to begin to test some of their propositions regarding these women's supposed pathology. By the early 1960s, objective studies began to call into question the 1950s portrayal of the alcoholic wife as having selected and remained with her husband out of her own deep emotional disturbance (Corder, Hendricks, & Corder, 1964).

Wives were not alone in being blamed for the alcoholism of their mates. Day, in her 1961 review of the alcoholism literature also noted a body of opinion suggesting that the etiology of male alcoholism could be found in the alcoholic's family of origin, particularly within the mother-son relationship. This literature emphasized the degree to which maternal domination and overindulgence created the future alcoholic's low tolerance for pain and frustration and stifled his ability to become independent and responsible. Other contributing factors in the family included a stern, autocratic father and conflicting maternal and paternal attitudes toward drinking (Day, 1961). Marking the continuity of this tradition, parents were consistently blamed as their children began illicit experimentation in the 1960s. It was in this context of blame that family therapy emerged as a primary mode of treatment for adolescent substance use disorders (Edwards & Steinglass, 1995; Liddle & Dakof, 1995).

"Family Programs" (1950s-1970s)

Most significant in the 1950s and 1960s were the emergence of explicitly family-oriented alcoholism treatment models, such as the outpatient counseling approach developed at Johns Hopkins Hospital that utilized parallel group therapy processes for alcoholics and their wives. One of the earliest family-oriented inpatient treatment approaches was initiated in 1965 at the Sandstone Hospital in Minnesota. Dr. Charles Cooper created a "Family-In" program in which families of alcoholic patients came to Sandstone for two to three days of residential, family-focused treatment (Richeson, 1978). Two other programs, Lutheran General Hospital in Illinois and Hazelden in Minnesota also experimented with residential "family week" and "family weekend" programs in the 1960s.

At Lutheran General, the original goal was to have family members live in apartments above Lutheran General's Alcoholism Treatment Center (ATC) so that they could fully participate in treatment, but these plans were abandoned when insurance companies refused to pay for the extra expense that was incurred. In spite of this setback, efforts to increase family involvement in treatment at Lutheran

General continued through the early years. An early "family night" program consisted of a lecture/discussion group. In 1978, a half-day Saturday program using Al-Anon volunteers was added, and in 1979 a formal Family Treatment Program was implemented, consisting of a three-day off-site residential retreat. Later iterations included a residential weekend model. Lutheran General's response to the families of alcoholics had two phases. The first phase was to seek family involvement because of the ways in which family members could enrich the alcoholic's treatment experience. The second phase, which began to emerge in the mid-1970s, was the recognition that family members needed and deserved treatment and support services in their own right.

A key source of family advocacy was the staff hired to work in the ATC who had extensive prior Al-Anon experience. The initiation of a formal alcoholism counselor-training program increased the involvement of Al-Anon members in the ATC. A.A. and Al-Anon members, many of them volunteers, enrolled in the training program and formed a pool from which new counselors could be hired. As the number of people with Al-Anon experience and a family-oriented perspective on alcoholism recovery increased at Lutheran General, these perspectives became integrated into Lutheran General's clinical training and public education programs.

The conceptualization of addiction as a "family disease" opened the door to exploring how this disease altered family structure (roles and subsystem interactions), family rules, family rituals, and the family's boundary transactions with the outside world. Studies of how alcoholism disrupted family rituals (e.g., meals and holidays) concluded that the disruption of such rituals increased the likelihood of intergenerational transmission of alcoholism (Wolin, Bennett, & Noonan, 1979).

The popularization of transactional analysis (TA) theory and techniques in the 1970s again shifted the focus from the effects of alcoholism on the family to the role of the family in the etiology of alcoholism. Within in the TA framework, alcoholism is the product of disordered family and social communication. Steiner (1971) posited three alcoholic roles or games: "Drunk and Proud," "Lush," and "Wino." Each of these games, as described by Steiner, involved manipulating others into the roles of persecutor, patsy, connection or rescuer. The games provide a guilt-free means of expressing aggression, an avoidance of overt anger, a projection of blame, and social attention. It was Steiner's belief that such roles could be revealed and changed through the process of therapeutic self-examination.

Denial, Enabling and Family Intervention (1970s)

A major corollary of the proposition that alcoholism is a family disease was that family homeostasis was maintained through the mechanisms of denial (portrayed metaphorically as the elephant in the living room that no one acknowledges) and enabling (any actions which prevent the alcoholic from experiencing the consequences of their drinking behavior). A further corollary was that acknowledging the problem and adopting a pattern of tough love could speed up the day when the alcoholic "hit bottom" and initiated recovery. Reverend Vern Johnson felt there had to be a better way to intervene in alcoholism than to sit and wait for the alcoholic to hit bottom. He developed a technology of family intervention through which the bottom could be raised to meet the alcoholic. He pioneered the use of a loving confrontation between the alcoholic and those who cared for the alcoholic to precipitate a crisis that most often resulted in the alcoholic's entry into alcoholism treatment. This concept was spread through a charitable foundation (the Johnson Institute) and through Johnson's publications, e.g., *I'll Quit Tomorrow* (1973/1980), which sold more than 100,000 copies.

The Family/Children of Alcoholics and the Codependency Movement (1980s)

Two overlapping movements emerged in the 1980s. The first focused on the special needs of children of alcoholics- an exploration that led to the concept of "co-alcoholism" or "para-alcoholism" (Greenleaf, 1981). During the early to middle 1980s, the work of Claudia Black and Sharon Wegscheider-Cruse graphically depicted the psychological and developmental consequences of parental alcoholism on children and catalogued how these consequences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). This marked a significant shift, in which the alcoholic's family members were viewed, not simply as sources of support for the alcoholic's recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields-counseling children and adult children of alcoholics- and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACOA) groups were formed within Al-Anon-some 1,100 by 1986-and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995).

As this movement took off, the extension of these findings to children and adult children who had been raised in other types of dysfunctional families marked a transition between the concept of co-alcoholism and the newly emerging concept of "codependence." The writings of Karen Horney, Erich Fromm, and other psychologists were used to create the concept of codependency (Melody, Miller & Miller, 1989). Dr. Timmen Cermak (1986a, b) conceptualized codependency as a "disease," proposed criteria for its medical diagnosis, and advocated that the major insurance carriers reimburse treatment of this disease. Addiction treatment programs began offering codependency treatment tracks and extending stays of alcoholics and addicts in treatment because of their "ACOA issues" or "codependency issues." Melodie Beattie launched a veritable social phenomenon with the 1987 publication of her book *Codependent No More.* She later defined five "core symptoms" of codependency: (1) difficulty experiencing appropriate levels of self-esteem, (2) difficulty setting functional boundaries, (3) difficulty owning our own reality, (4) difficulty acknowledging and meeting our own needs and wants, and (5) difficulty experiencing and expressing our reality moderately (Melody, Miller and Miller, 1989). Adding fuel to this movement was the publication the following year of John Bradshaw's *Healing the Shame That Binds You* and his highly popular PBS television series that was based on the book. A whole nation seemed to be riveted on the exploration of the "dysfunctional family" and on the extension of this concept to the workplace, and to society as a whole. This new movement also spawned its own Twelve-Step adaptation, Co-Dependents Anonymous, which by 1990 had more than 1,600 registered groups (Makela, Arminen, Bloomfield, Eisenbach-Strangl, Bergmark, Kurube and others, 1996).

The ACOA and codependency movements left many legacies. For the first time, children and adult children of alcoholics were admitted as primary patients and given a primary diagnosis as well as their own individualized treatment. These movements gave many people a heightened understanding of their own family-of-origin experiences. If there is a clear legacy from the ACOA movement it is the experiential understanding that childhood trauma can unfold developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors. The codependency movement did bear unanticipated fruit via an ideological and financial backlash that hurt the movement itself and the broader addiction treatment community from which it had been spawned.

The Codependency Backlash (1990-1995)

The backlash against the concept of codependency and its commercialized applications came from many quarters (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992). The most strident criticisms included the following:

- The definitions of codependency are so inclusive as to lack any clinical utility.
- The symptoms of codependency inordinately target women have been raised to cultivate; codependency turns social pathology into psychopathology. Energy is turned toward inner healing rather than political activism and environmental change.
- By defining the problem of "women who love too much" as one of psychopathology, we fail to hold abusive men accountable for their neglectful, demeaning and violent behavior.
- The movement sets up a milieu in which women bond out of their weakness rather than their strength (Kasl, 1992).
- The movement infantilizes its members as "Adult Children" and traps them at an immature stage of development.

In the end, it was not philosophical debate but economics that doomed the codependency movement. An aggressive system of managed behavioral health care led to a rapid erosion of first the length of treatment and then an erosion of the number of private and hospital-based addiction treatment programs. In that change, many family programs disappeared. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that it would be financial suicide to provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions.

Family Recovery Research: The New Frontier (Late 1980s-1990s)

Since 1989, Drs. Stephanie Brown and Virginia Lewis have worked to construct the developmental stages of family recovery from addiction. Their preliminary findings challenge the prevailing expectation that families can rapidly move toward health with the initiation of alcoholism recovery. They found in their research that the emotional turbulence within the family produced by addiction continues well into the first three to five years of recovery. Family recovery begins with what are, in essence, individual recoveries of its members. Without "holding environments" to sustain these individual recoveries until couple and family relationships can be reconstructed, the risk of collapse and disintegration of the family is quite high. Children older than twelve may have great difficulty participating in this family-making at a time they are moving toward individuation and separation from the family. A major implication of this research is the notion that children and families go through a "trauma of recovery"-a readjustment of expectations required by their continued psychological isolation from the addicted parent going through early recovery (Brown, 1994). Continued research on families in recovery is likely to reveal the diversity of family addiction and recovery experiences. The response of families to alcoholism and other addictive diseases is not a homogenous one that can be depicted in a single reductionist model. The diversity of family life is as wonderful in its capacity for resilience as it is sometimes horrifying in its capacity for cruelty. Each family must be its own model. Intervention into families must by characterized by gentleness and humility rather than by clinical arrogance born of knowing THE truth about the impact of addiction and recovery on the family.

Evolution of Family-Oriented Treatment

Family treatment evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, groups for wives of alcoholics, conjoint marital therapy, residential or outpatient family education, and primary treatment for family members that focused on their individual recovery. Another nuance that emerged in family programming in addiction treatment programs in the past 20 years was the effort to break intergenerational patterns of alcohol- and other drug-related problems. These efforts, particularly those that emerged in programs designed to treat addicted women with histories of child neglect and child abuse, began with simultaneous but separate interventions with addicted mothers and their children, then focused attention on enhancing the health of the family as a unit. Combining treatment services for parents and children, parenting training, and family therapy, they sought to decrease the likelihood that the children of today's clients would recapitulate these problems as they moved into their own adolescence and adulthood (White, Woll, & Webber, in press).

PART II
FAMILIES AND THE NEW RECOVERY ADVOCACY MOVEMENT

The 1980s and 1990s witnessed significant changes in the cultural perception of people with severe and persistent alcohol and other drug problems. Such problems were re-stigmatized (positive images of addiction and recovery, e.g., First Lady Betty Ford, were replaced by images that evoked fear and pessimism), demedicalized (redefined as moral problems rather than medical problems), and recriminalized (persons with these problems were transferred from systems of compassion and care to systems of control and punishment). In response to these new changes, grassroots recovery advocacy organizations began to again organize to change how America viewed addiction and those addicted. The strength of this movement, which is led by people in addiction recovery and their family members, continues to reside in its work in local communities, although efforts to forge a national-level movement are underway.

The Experience of Family Members as Advocates

To develop a better understanding of the role of family members in this new recovery advocacy movement, the authors conducted and analyzed the results of five focus group meetings of individuals whose families had been impacted by addiction and/or recovery. The meetings were hosted by the Connecticut Community for Addiction Recovery. The focus groups were conducted in the communities of Hartford, CT, Wethersfield, CT, New Haven, CT, Springfield, MA, New City, NY between the summer of 2002 and the spring of 2003. A total of 56 family members participated in the focus groups. Each focus group lasted approximately 2 hours. The members of each focus group were asked to respond to the same set of questions related to family experiences with addiction, recovery and recovery advocacy.

In the remainder of this paper, we will explore the experiences of family advocates in this new movement and end with a discussion of the future of family members as recovery advocates.

The Lived Experience of Stigma

Focus group members often opened with accounts of what it was like to live with the shame and stigma of addiction. Most striking in these accounts were repeated references to the silences that pervaded their lives-silences that grew out of a larger cultural silence about addiction.

> *I grew up in a small, French Canadian town in Northern Maine. There were and are so many alcoholics. Everybody knew our family and our situation (alcoholism), but yet nobody talked about it.*

We were very good at keeping the secret (alcoholism). There was the shame and it was very powerful.

For some this shame was magnified by cultural stereotypes of who was and was not supposed to have alcohol and drug problems.

The problem wasn't alcohol; it was crack cocaine. Where we lived this was viewed as a problem of the intercity ghetto. When our own college-educated son in the suburbs developed this problem, it was really hard to talk to others about it. This was not something our family and friends could see happening in their world. It was our shameful secret.

Such cultural silence made it very difficult for family members to come to grips with the reality of what was happening within their own families.

I thought, "My son can't be a heroin addict." When he went through treatment the first time, I thought, "Now he's fine." After treatment, I thought, "Okay, now we can all go back to normal." I didn't have a clue. I thought my son had a little problem-a little problem that went on to kill him.

My son made something very clear to me some time before he died. I had always thought of junkies as these depraved guys on the streets, and my son said to me one day, "Mom I am that junky. Don't you understand that there isn't a difference between me and that guy?" That's when it really hit me! Today when I see some poor person strung out on the street, I remind myself that this lost soul has a family like mine somewhere. It is sad that people don't understand this.

People would come to my house and see my son's picture, my son that passed away, and they couldn't believe it when I told them that he died last year of a drug overdose. They couldn't believe that he was a normal boy who went fishing and grew up to have two children and a loving family. People think of junkies as people who don't have families that care about them. What no one understands is that these junkies are our sons and daughters and brothers and sisters.

The shame attached to female addiction was greater than that for males.

Maybe this gender thing is old fashioned, but for my mother, it was so much more treacherous for her. She only went to women's meetings. A lot of people knew because when things were bad with her, it wasn't the kind of thing you could hide. But there still wasn't the same kind of openness you see with male family members in recovery.

I am proud of my father's addiction and recovery, but I have had a hard time discussing my mother's addiction and recovery, and my sister's addiction-related death.

There were also differences noted between family experience and disclosure of that experience based on whether the addicted family member was in recovery or still using.

There is a big difference between talking about a family member in recovery and one who's active. When my sister was actively using, the shame was overwhelming. I didn't really want to get into it at all. Once there is the success of recovery, it is a whole lot easier. Then you feel you can share in the pride and success of recovery. But when it's going on, it's very hard. With all the things that addicts do, even with people who are close to you, you don't want to disclose the gory details.

It was often in encounters with professional helpers that family members had to first confront the reality of addiction within their families. Yet focus group members repeatedly talked about the shame they were made to experience within these same institutions.

> *You feel dirty when you're standing in the emergency room and your child is there for a drug overdose.*

> *Interacting with some professionals is like a belly punch. One of them said to me, "I know what to do with addicts: you should put them on an island like Alcatraz and drop food and guns to let them take care of themselves." He said this in front of me. I just wanted to go into another room and cry.*

> *If someone had died in a car accident, they would take the arriving family members to a room and talk to them in a comforting way. When we arrived after being told my son had died of an overdose, they said you better hurry and say your good-byes because the Medical Examiner is coming to pick up his body at midnight. It was like he was nothing-my 24-year-old baby. Nobody walked me in. Nobody got my mother a chair. There was no social worker. They didn't ask if they could call a priest. They didn't ask what funeral home we wanted contacted. Nobody was there to help. There was no privacy-we were out in the middle of the lobby. Nobody took us into a private room. There was nothing.*

One focus group member noted that procedures designed to protect those who are addicted even reflects this stigma.

> *Sometimes I get so angry at the system. One of the things that I think is so detrimental is that the professionals can't tell me whether my daughter is in treatment or not. You don't have to tell me personal information that she has disclosed; I just want to know that she is there and is okay. I don't know where she is. She may be dead on the street. I've been concerned for 6 or 7 days. There is no other medical condition in which family members are so shut out and deprived of information. This is the only disease that even professionals can't talk about. I hope the removal of stigma will make it easier for those in my situation to get information about the status of our family member.*

During such interactions, family members reported hearing more therapeutic pessimism than hope.

> *A number of professionals that know my daughter and about her addiction have told me that she is hardcore and that she will never recover. I can't say I don't believe them, but I refuse to believe them.*

Toward Family-Inclusive Recovery Language

People recovering from addiction have evolved a language (e.g., recovering/recovered) and rituals (e.g., sobriety birthdays) to describe and celebrate their experience. Language and rituals for family members is much less defined. Some refer to themselves as "families in recovery" or a "family member in recovery," even though some focus group members felt such terms were ambiguous and confusing.

> *The term recovery is so broad it is hard to get handle on what we mean by it. The term doesn't capture the diversity of ways families experience addiction and the ways family members restore their own disordered health. I wish we could come up with a better term.*

> *I think my family members would be offended if they were known as a "family in recovery." It has a pejorative connotation.*

We could refer to ourselves as survivors of a family member's addiction or perhaps we could all wear a nametag that says "Caution: Family in Renovation."

Other family members found it difficult to apply the term when their loved one was still actively using.

The only time I'm in recovery is when my daughter is in rehab. That's because I sleep well and I know that she's being taken care of and doing something.

In the end, most focus group members felt comfortable with the term recovery but also felt family members should be able to select the term that best depicts their experience. They clearly see themselves as being in recovery, and they can pinpoint or approximate when they started on the road to recovery. They are interested in being equal partners with their formerly addicted loved ones in a recovery process and feel that use of recovery as a term for their experience enhanced understanding and acceptance by those in direct recovery from addiction. For some family members, the term recovery implies a retrieval of what was lost through addiction (e.g., trust, economic security, intimacy, laughter). For others, such as those whose family member died an addiction-related death, the term recovery implies the long process of grieving and healing.

Persons recovering from addiction use the date that they stopped drug use as their point of recovery initiation and often celebrate that date similar to a birthday. Family members have much greater difficulty pinpointing the initiation of their own recovery process. Some use the recovery initiation date of their family member while others note a particular milestone in their own healing or growth.

It's a long time before you believe it's for real. My father used to celebrate his sobriety anniversary with coins and all that stuff, but it wasn't until he got 7 or 8 years in that we started to believe it. I am not sure I can mark the date for me as a family member, but there clearly was a date when he stopped.

You could pinpoint the period when you understood and stopped enabling, but I think that process is gradual. It's hard to pick a date. It's cumulative.

Marking recovery by enabling alone would be difficult. Enabling is one of the hardest words to deal with. One day you think you're enabling and the next day you do the same thing and you're helping out.

For me events have more of an impact than a date. His last rehab was very eventful for the both of us. I saw a change in him. The return of his soul is the only way I can describe it. The new place that he was at means more to me than any date. It's a developmental process.

Another approach to defining recovery initiation for family members is to focus on the stage at which the member stopped reacting to the addicted family member and focused instead on their own needs and aspirations.

The Decision to Keep or Break Silence: Responses to the Family Addiction/Recovery Story

Family members have three levels at which silence can be broken regarding their experiences with an alcohol- or other drug-addicted family member. These levels mark the stages between personal recovery and political advocacy.

Breaking silence to others cannot occur until there is a breakthrough of insight that allows one to reconstruct the perception of the addicted family member. Many focus group members noted the importance of

such breakthroughs. What this revealed was that silence must be broken within the self before it can be broken to others.

> *I talk to myself. There was a point at somewhere maybe 15 or 20 years ago that I really started to delve into what is this alcoholic family that I grew up in? I reached a point where I accepted the fact that my father was an alcoholic, and I started to get involved in a lot of different things. There was a clear point at which how I saw him and myself started to shift. That was when I decided I wasn't going to be ashamed any more.*
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> *You have to make sense of what happened and heal yourself before you can carry a message of hope to others. I came to realize that my son had a disease. You can forgive somebody for having cancer; why can't you forgive them for having the disease of addiction? The terrible things they do are part of their disease. My son did a lot of terrible things, but it never meant that he wasn't a good person or that he didn't love me.*

The helpfulness of these new insights opens the doorway for disclosure to others. One of the most difficult arenas for such disclosure involves other family members. The second level of silence-breaking occurs within the family itself. Even some of the most articulate advocates-persons who have championed recovery in all manner of public forums-confessed the difficulty they had talking with other family members about the experience with addiction. Few topics generated such lengthy and detailed responses.

> *I found it easier to talk to people outside of my family…my son is an addict, and I've never even to this day expressed those words to my family. When he was 17 and he started drinking they said it was just a stage and not to worry about it. They know he's been in rehab and on probation, but we've never discussed these things in detail. Part of the reason that I never told them about his addiction was that I felt it would change how they acted towards him and I didn't want that to happen.*
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> *I have a problem talking about all this with certain members of my family. They have a different outlook on life. They have to shop at Bloomingdales. They just can't shop anywhere else. With certain people, you just can't go there with this subject.*
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> *I was given an award, not too long ago, and my siblings attended. After my talk on my involvement in the recovery advocacy movement, my wife asked me why I hadn't mentioned my father's alcoholism. I didn't dare broach this subject then for fear of upsetting my siblings. I was silent because I didn't want to have my whole family teed off at me for acknowledging that my father was an alcoholic. This was fifty years of stigma and shame still influencing my behavior.*
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> *I think we had a harder time with this because it's not a parent who is addicted but our own child. With a child, it is hard not to feel responsible. You are seen as having failed in a vital part of your life. People think that you somehow allowed your kid to become addicted. I have not shared this with some of my own siblings. I have four siblings, but have only talked about my son's addiction with one.*
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> *The risk that I face is alienation of my siblings, especially with my sister, which is interesting since her husband died of alcoholism. Our relationship has developed in a unique way and I don't want to ruin that. Besides, protecting the alcoholic is still ingrained in me after all those*

years. When I first spoke about my father's alcoholism at a CCAR meeting, I started crying. I didn't realize I would react that way. So there is also the risk of embarrassment in the presence of one's family. My brother is coming down shortly and this obviously won't be a topic. My family knows what I'm doing but I don't push it too far.

I've talked to my mother about my advocacy work, but she's not too excited about it. I've tried to talk to all my brothers and sisters about what I'm involved in and they have provided ambivalent support for my going public with our story.

A person in our group wanted to speak publicly but her daughter was very upset and thought it was simply an airing of the family's dirty laundry in public. It took this woman almost three months to explain to her daughter and have her daughter come around to the fact that what she was doing was very important.

We have CCAR members who are active with us but will not speak publicly because their addicted family members refuse to let them do so.

Going Public

The decision to go public with one's family story of addiction or recovery is a highly personal one. Perhaps the first obstacle to overcome is the anticipation of judgments that others will make.

I think the risk that you face, is what people are going to think. When I tell them what happened to my son, they give me a look and just roll their eyes. I can see that they really don't believe me. I can hear their minds saying that my son was no good and that I must have done something wrong. I risk those judgments for the sake of my son and every other family that could face the nightmare I have lived through.

When I considered going public, all I could think of was my neighbors. I knew I would run this risk of them judging me and having them wonder what I did wrong. I wanted to be thought of as a good parent, but there were several instances when my son acted up in our neighborhood. I had to get past the thought of those people judging me.

I don't care what people think: I will tell the truth of our experience. I loved my grandson, and I hope I can help other people by telling them our story. I don't care if it's in the newspaper. It is the truth of what happened in our life. We went through a lot of pain and we're still recovering.

Most focus groups members talked about having passed through the stage of their concerns about the judgment of others to a place where the message was more important than their potential embarrassment. The first element of that message was that addiction could touch any family and the devastating impact of addiction upon the family as a whole. The second element was about the potential for recovery and the process of recovery for the individual and the family. The potential benefit of this message to others eventually outweighed concerns about personal privacy. There was also in the decision to go public a dimension of anger: anger that their pain could have been lessened if addiction had not been so shrouded in shame and silence.

Family advocacy is important due to the demoralization and anger families often experience through multiple episodes of recovery initiation and relapse. Families need to know that there are permanent solutions to addiction and that there is hope for their loved one and their family. Families telling their stories of survival, forgiveness and reconciliation are powerful antidotes to

the hopelessness that so often pervades the perception of addiction in this culture.

Parents who have lost children to addiction face a special challenge working in recovery advocacy. It is sometimes hard for these parents to work with individuals and families in sustained recovery. Through these relationships they must face the question of why their family was not included among the success stories. For our focus group members, the potential value of their stories to other parents and the larger community overcame such questioning. Most committed their work in advocacy to the loving memories of their lost children.

What family members do is shine a light on the shrouded world of addiction and recovery.

> *When family members speak out, they normalize the addiction experience. When I publicly declare, "I'm a member of a family that has been wounded by addiction," I'm saying that this problem can touch anywhere, that I'm not different than you are. What we can do as family members is try to help others understand what they are dealing with. Our job is to take some of the stigma off being a family touched by addiction and take away the guilt and shame that comes with that.*

When people openly talk about stigmatized issues and experiences to others, there is no cultural etiquette to define what is expected from those hearing this account. The inclination is for people to offer advice about how the problem can be solved.

> *If I tell you my lawn is bad and you tell me to put Scotts on four times a year and then I don't do it, you're going to be upset with me because I didn't take your advice. Sometimes we don't talk because we don't want the advice. We just want them to listen to what we are going through. We need to be honest with people and tell them we are not asking for advice. We need to tell them we have had advice from all quarters, that what we need now is a sympathetic ear and understanding.*

One of the issues that arises following the decision to put a public face and voice on the family experience of addiction and recovery is how to tell one's story as a family member without bringing embarrassment to the addicted or recovering family member.

> *Our son lives and works in the area where we live. I've always been conscious of how my public disclosures could affect him and his business. So I don't say anything unless he says it is all right, or I know he has talked about it. I feel very protective about that. He is in business for himself and he's doing very well, but it's an occupation that requires people's trust. I wouldn't want to do anything to hurt that. It is very important that you have the support of the member, if you are going to speak out, otherwise it could have an adverse effect.*
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> *This is our son's private place and we've decided that it is not our privilege to talk about that in forums that would bring embarrassment to him. He's part of our local community and we feel we don't have the privilege to publicly tell his story here. We can support him and this movement in ways other than our story.*
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> *The way I handle this is to not go into a lot of details about his* [addicted family member's] *experience. I try to keep the story to what I experienced.*
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> *It's not the concerns for myself but for my children, if one of their peers finds out their dad is an alcoholic. How much do I say as a parent and where do I draw the line to keep their life private? I don't stop myself in saying*

what I have to say but I kind of watch it sometimes because of them.

I think we have to be discrete. If I'm going to disclose my story in a public forum, I'm not going to give all the details. I certainly have to take into consideration how disclosing this story will affect my family. Otherwise, I am back to being a self-centered person.

Not everyone is suited to tell their story to a local newspaper or speak before a group of legislators. The personal vulnerability of such disclosure is a reality, but many focus group members talked about how the risks of recovery advocacy were diminished when they stood with large numbers of other people in recovery.

I go to Legislative Day and to the Recovery Walks where there are hundreds or thousands of other people. Those activities are less personally vulnerable because of the sheer number of people who are there.

Some family members expressed concern about potential embarrassment brought to children within the family. The following comment underscores just how personal is the decision and timing of recovery advocacy activities.

Our children are at an age where they want to be like everyone else. They don't want to stand out in any way. So we have been careful to talk to them about when and how we tell our story at a public level. We could even reach a period where we don't tell our story publicly for a while if we decided that it would make our children too uncomfortable.

The fear of potential embarrassment is often overcome by pain, grief, anger, or gratitude.

I refuse to let my son die with that stigma over his head. If it takes to the day I die, I'm going to fight to get rid of the shame and stigma attached to addiction.

There was Al-Anon, but there was nothing there for parents who have lost their sons or daughters to addiction. That's what I committed myself to change.

The women in this group have all lost children to drug overdoses. If we don't speak out, our children will have died in vain.

Recovery Mutual Support and Recovery Advocacy

Family members made several key points related to the roles of mutual support and advocacy.

1. The functions of mutual support and recovery advocacy should be kept separate. While advocacy may have certain therapeutic benefits, it is not a program of personal recovery and should not be thought of as a substitute for such a program.

2. When one is a member of a mutual support group and a member of a recovery advocacy organization like CCAR, these roles should be kept separate. Recovery advocacy activities should not spill into one's mutual support activities, and one's advocacy activities should be done as an individual and not as a representative of a mutual support group.

3. The anonymity tradition of Twelve Step programs should be respected in advocacy activities via no references to one's personal affiliation with a Twelve Step program at the level of television, radio or the print media.

There was a man in the audience at the first presentation I made for CCAR who as I spoke got redder, redder, and redder. Finally, he said, "You can't speak out publicly like this because of the anonymity tradition." But there was another younger man

who explained that you could disclose your recovery status and story as long as you didn't identify yourself as a member or attempt to speak on behalf of A.A. or other Twelve Step programs. It triggered a very lively discussion. Some said CCAR would never grow because of this issue of anonymity, and yet we grew because there were and are people willing to put a real face on recovery.

4. Not everyone is cut out to do recovery advocacy at a public level. Many people may have personal or family circumstances that preclude such activity. Recovery advocacy organizations like CCAR, and the larger new recovery advocacy movement, are not asking all individuals and families in recovery to step into public view, but they are calling upon a vanguard of recovering people and their families to take such action.

Family members in our focus groups talked a lot of how to separate and balance their personal needs and their advocacy activity. The following response is typical.

Family members need to understand that at times one's own needs come first. Even if you have been involved in advocacy work at one point, you may need to move in and out of advocacy work depending on how balanced your life is. This moving in and out of advocacy work is OK. Ultimately, the decision to do public advocacy with your own story comes down to what you need to do and how to minimize that impact on others close to you. At CCAR, we try to have this conversation about the risks involved in advocacy before people get extensively involved.

Members of our family focus groups did feel that family members had a unique contribution to make in the advocacy arena.

Our personal stories have not been heard in our communities. They are stories that can influence other family members and policy makers. The family experience adds to the total story of addiction and puts a positive face on recovery. They help deal with the part of the stigma that is uniquely experienced by the family member. They help members in direct recovery have a better understanding of the impact they had on family members and how to deal with those issues in respect to their own recovery. And they help their own personal recovery by giving back.

5. Involving family members in recovery advocacy provides a venue to address policy issues and conditions that are most paramount to family members. When asked for examples of such issues, focus group members most frequently noted the following:

- Exploration of the impact of stigma on family members and the need for programs that reduce such stigma at the local and national levels
- Assistance and support in talking about addiction and recovery even within one's own extended family
- Availability of treatment and recovery support resources (There were nightmarish stories about families in crisis encountering waiting lists and various procedural barriers to getting help.)
- Assistance in navigating a complex and often fragmented treatment system
- Availability of information on the relative quality of treatment agencies
- Inclusion of family members in addiction treatment (Focus group members lamented the loss of family programs as an integral component of addiction treatment.)
- Access to information about the presence of their family member in treatment (Focus group members noted that confidentiality regulations designed to protect the individual often harm the family by denying them information, not about the details of

treatment, but the presence or absence of their family member in treatment.)

Focus group members felt very strongly that community education that focused on the family experience of addiction and recovery would have diminished their own difficulties with these experiences. Such education would have given them more information and would have also created more informed and supportive social networks. Without such education, family members must either be silent or try to answer questions such as:

- How did he/she become addicted?
- Why doesn't he/she just stop?
- Why do you continue to go to those support meetings if he/she is no longer drinking?

For many family members, silence is easier than struggling to formulate answers to such questions.

Focus group members also felt cheated that they had been denied knowledge about addiction and its impact on the family. The wounds to their families not only from addiction, but also from the ignorance and stigma that surrounded it. Those wounds were also created by a lack of knowledge about what the family could expect within the recovery process. Focus group members spoke with great animation about what they did not understand about the family recovery process.

> *There is so much we don't understand about the problems of recovering families. My wife has a black belt in Al-Anon and we seem to have competing programs. We have what amounts to an ongoing angersarial relationship when it comes to programs and I don't know why. I think I've encountered more stigma inside my family than outside, and that stigma is the source of a lot of beefs that plague my marriage and my family.*

The Blessings of Advocacy

The other theme that resounded within the focus groups was the personal benefits that members had experienced from their advocacy activities.

> *Today, I am a messenger of family recovery. Somehow my experience of family recovery came up in a recent job interview. The woman who was interviewing me said, "I have a daughter who is addicted, and I don't know where to go." After she talked for some time, we both had the feeling that fate had brought us together to have this conversation.*
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> *By speaking out, we have helped reduce the stigma that families experience as a result of having a family member addicted to alcohol and other drugs. By giving back, we have sped the progress of our own recovery. We have learned things and felt a sense of purpose that has helped us in dealing with other aspects of their life. We have helped shape policies and legislation. We have honored our family members in recovery and the family members we lost to addiction.*
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> *I know there is power in the individual person in recovery telling his or her story publicly, but the power of the family member telling their story is potentially far greater in terms of system change. This is because of the magnitude of people in this culture who have been touched by addiction. Having the opportunity to turn our wounds into that kind of potential influence is a true gift.*

The Future of Family Members as Advocates

For two centuries, families have been as likely to be blamed for the addiction of one of their members as offered support in responding to that addiction and its impact

on themselves. And yet through this period family members have played an important role in advocating for more enlightened attitudes and social policies related to alcohol and other drug-related problems. As a new recovery advocacy movement seeks to define itself locally and nationally, we believe that is it time to honor the historical legacy of family members by embracing them as co-leaders of this movement. It is also time to define the family as the basic unit in the design of addiction treatment and sustained recovery support services.

One of CCAR's primary purposes is to put a positive face on the Recovery Community, which includes persons in direct recovery, family members and friends. A second and equally important purpose is to provide support to the recovery community to help sustain recovery and improve the quality of life for recovering people. Over the past few years, CCAR has devoted a considerable amount of work in these two areas and has started to see positive changes at the legislative, state policy and local community levels. A similar effort needs to be launched for families who have family members who are or were addicted. A vanguard of family members is needed to tell their story to legislators, policy makers, other family members and the community at large. Family members are needed to advocate for the support they need and for other family members still needing help. Telling their story will help provide a better understanding of the impact that addictions has on the family, help give permission for all families to speak about these issues, and help make it more acceptable for families to seek help for an addicted family member.

Recovery community organizations like CCAR provide training and the opportunity for family members to come together as a group to achieve things that could not be done on their own. Working as a group to put a positive face on family issues and provide support to families can provide a sense of community and purpose and provide a venue for service to other family members still suffering. To the family members who are reading this, we encourage you to seek out recovery advocacy organizations in your area and help support them in ways that will benefit you and the larger community. It is time family members became full partners in this new recovery advocacy movement.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Scott, C. & White, W. (2005). Ethical issues in the conduct of longitudinal studies. Journal of Substance Abuse Treatment, 28, 591-601. Posted at **www.williamwhitepapers.com**

Ethical issues in the conduct of longitudinal studies

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Abstract

Many complex ethical and legal issues arise in the day-to-day conduct of longitudinal studies of addiction treatment. These issues are rooted, in part, in (a) the sustained and potentially ambiguous relationship between research staff and study participants, (b) the frequently changing clinical and legal status of the participants, (c) the assertive methods required to sustain contact with participants, and (d) the numerous systems of care and control in which participants are involved. To identify common ethical and legal issues that arise in such studies, the authors conducted individual and group interviews with staff (case trackers, field trackers and interviewers) from a research team that has completed more than 12,700 treatment follow-up interviews.

The ethical issues identified through these interviews fell into seven broad arenas: 1) informed consent for research participation, 2) confidentiality and information disclosure, 3) relationship boundaries between study participants and research staff, 4) duty to warn/report responsibilities, 5) questions of autonomy and privacy, 6) compensation for research participation, and 7) data integrity. Case studies are presented and discussed that illustrate common ethical dilemmas within each of these seven areas. The ethical dilemmas described can be effectively managed via ethically-informed research protocol; staff training in ethical decision-making; monitoring and supervision; and collective debriefing of critical events.

Key words: research, follow-up, ethics, informed consent, confidentiality, relationship boundaries, duty to warn



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Citation: White, W. & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor*. 6(5), 58-62. Posted at www.williamwhitepapers.com

Faith-based Recovery: Its Historical Roots

William L. White, MA and David Whiters, MSW

The only cure for dipsomania is religiomania. –William James, 1902

One of the most clinically significant breakthroughs in the modern addictions field is the recognition and legitimization of multiple pathways of long-term recovery from severe alcohol and other drug problems. These pathways can be broadly categorized into religious, spiritual, and secular frameworks of problem resolution. Interest is increasing in explicitly religious frameworks of recovery, due to the dramatic growth of recovery ministries and President Bush's recently implemented Access to Recovery (ATR) program. This article provides a brief history of faith-based approaches to addiction recovery in America and a review of what lessons this history holds for the addiction counselor.

A Chronology of Faith-based Recovery

The history of faith-based recovery in America begins with the rise of Native American abstinence-based religious and cultural revitalization movements in the eighteenth and nineteenth centuries (the Delaware Prophets, Handsome Lake, the Shawnee Prophet, the Kickapoo Prophet, Indian Christian missionaries such as William Apess and George Copway, the Indian Shaker Church, and the Native American Church). These movements called for a rejection of alcohol and a return to native tribal traditions as a framework for personal recovery and cultural survival (Coyhis & White, in press).

Dr. Benjamin Rush (1784) was one of the earliest persons to note that religious experience could serve as an antidote to alcoholism. Belief in the power of religion to reform the drunkard grew in tandem with the great religious awakenings of the late eighteenth and early nineteenth centuries. The revivalists Dwight Moody and Ira Sankey made special appeals to those wounded by alcohol and recruited redeemed, sobered alcoholics to offer testimony at their revival meetings. The apex of these early efforts was the urban mission movement--founded by Jerry McAuley (1872) and extended by the work of the Salvation Army (1880); the development of rural inebriate colonies such as the Keswick Colony of Mercy (1897); and the opening of religiously oriented inebriate homes such as the Christian Home for Intemperate Men

(1876)(Bonner, 1967). The influence of religiously oriented "rescue work" within the American temperance movement and the revivalist crusades is evidenced by the inclusion of chapters on religious conversion in early addiction-medicine texts (e.g., Cutten, 1907). This tradition extends into the present work of the Salvation Army Service Centers and the organizational members of the Christian Alcoholic Rehabilitation Association, founded in 1967.

In 1906 the Emmanuel Clinic in Boston opened a clinic that integrated religion, medicine, and psychology in the treatment of nervous and mental disorders. The clinic developed a specialty of treating alcoholism that was widely replicated in what came to be known as the Emmanuel Movement. The movement spawned such well-known lay therapists (recovered alcoholics trained as psychotherapists) as Courtenay Baylor, Francis Chambers, Richard Peabody, and others who went on to develop more secular approaches to lay psychotherapy for alcoholism. The Emmanuel Movement used a combination of psychological counseling, sober fellowship (via the Jacoby Club), and linkage to a larger community of religious faith as the foundation of alcoholism recovery (Dubiel, 2004).

In the 1930s, alcoholics began using a Christian fellowship, the Oxford Group, as a vehicle of recovery. Their separation from the Oxford Group in the late 1930s marked the birth of a spiritually, but less religiously, oriented program and the emergence of Alcoholics Anonymous as an independent organization. The later return of a more religious, Christ-centered adaptation of the AA program (Alcoholics Victorious, 1948) and the development of Eleventh Step groups within AA (Calix Society, 1947; Jewish Alcoholics, Chemically Dependent People and Significant Others, 1979) represent the overlapping, cyclical shift between spiritual and religious orientations to recovery.

The role of Islam in recovery from addiction in America came to public consciousness through the life of one man whose transformation from the addicted street hustler "Detroit Red" to Malcolm X was catalyzed by his conversion within the Nation of Islam. Malcolm X went on to become a major force in bringing Islam-based recovery to African American urban and prison communities, using an outreach process he referred to as "fishing for the dead" (Myers, 1993, p. 82). Since the founding of the Nation of Islam, there has also been interest within the larger Islamic community in alcoholism and addiction ministries (Badri, 1976). This is evident in a growing body of literature extolling the prophet Muhammad's teachings about "khamr" (intoxicants) and "haram" (that which is forbidden) and the growth in Islamic recovery support groups such as Millati Islami, a network of recovery support groups that have adapted the Twelve Steps to incorporate Islamic principles.

The rise of juvenile narcotic-addiction in urban communities of the 1950s sparked the involvement of Christian churches in the addictions arena. Such activities included outreach programs, e.g., the work of Father Daniel Egan (the "Junkie Priest"), community counseling clinics such as Saint Mark's Clinic in Chicago (1954) and the Addict's Rehabilitation Center in Manhattan (1957), and faith-based treatment communities and sober-living environments such as Samaritan Halfway Society (1958), Exodus House (1958), Teen Challenge (1961), and Village Haven (1962).

The closing decades of the twentieth century witnessed new faith-based recovery mutual-aid societies (Overcomers Outreach, 1977; Liontamers Anonymous, 1980; Mountain Movers; High Ground; Free N' One; Victorious Lady; Celebrate Recovery; and innumerable local recovery-support ministries) and the growth of religious communities for the regeneration of those addicted to alcohol and other drugs (e.g., Dunklin Memorial Camp). Also noteworthy have been organizations founded to formally

mobilize the resources of churches to address the problems of alcohol and drug addiction (National Clergy Council on Alcoholism and Related Drug Problems, 1949; North Conway Institute, 1951; One Church–One Addict, 1994), intervention models to address alcohol and other drug problems within congregations (e.g., those disseminated by Sister Therese Golden and Rev. Jerry Wagenknecht on behalf of Parkside Medical services in the 1980s), models of integrating faith-based and clinically based approaches to addiction treatment (e.g., the NET Training Institute), and growing religious activism in recovery resource development, particularly within ethnic communities (Williams & Laird, 1992).

Faith-based recovery initiatives have often existed outside of, or on the fringe of, the mainstream system of addiction treatment, but such programs have recently received increased legitimization through the president's Access to Recovery Program (ATR) and through the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP). Both the ATR and RCSP have encouraged the development of faith-based recovery support services in local communities around the country. Recovery Consultants of Atlanta is an example of an RCSP-supported, faith-based, peer-led project that collaborates with Atlanta area African-American churches and historically Black colleges and universities in the development of peer-led addiction recovery support services.

Common Threads

Faith-based frameworks of recovery from addiction span the major and lesser-known religions. Seen collectively, faith-based frameworks of recovery provide:

- a catalytic understanding of the roots of addiction (e.g., the Christian interpretation of addiction as a "sin of the flesh" or demonic possession and the Islamic interpretation of alcoholism as a fruit of the tree of *Jahiliyyah* (ignorance/idolatry) (Badri, 1976)
- a mytho-magical personification and demonization of drugs and addiction, e.g., the Islamic interpretation of drink and drunkenness as an "infamy of Satan's handiwork" (Badri, 1976, pp. 3-5), the Christian metaphor of "battling the demon"
- a rationale for restraint and radical abstinence (e.g., the body as the temple of God) (1 Cor 3:16-17; Miller, 1995)
- a transcendence of self—invitation to reach for resources and relationships beyond the self
- a reconstruction of personal identity, values, and interpersonal relationships
- disengagement from toxic relationships and rituals
- rituals of self-inventory, confession, self-forgiveness, acts of restitution, and acts of service, and
- enmeshment in a community of shared belief.

One can recognize within this list functions comparable to those served by spiritual (but not necessarily religious) as well as secular frameworks of recovery, including the professional treatment of substance use disorders.

Faith-based Recovery and the Clinical World of Addiction Treatment

The growth of faith-based programs has not been without its controversies. Early (nineteenth century) critics of this approach centered on four points:

- Religious conversion as a vehicle of recovery was open only to a small percentage of alcoholics.
- Engagement of alcoholics in church-based programs diverts them from medical institutions where they could be more effectively treated.

- Religious conversion could actually harm the alcoholic (by replacing alcohol addiction with religious fanaticism).
- Promoting religion as a method of curing alcoholism secularizes religion by turning it into a product of the marketplace.

Criticisms of faith-based approaches to addiction recovery continue today, leaving open the question of how such frameworks will compete with, be linked to, or be integrated with the mainstream system of addiction treatment. We believe that dialogue among those representing religious, spiritual, and secular frameworks of addiction recovery is needed and that such dialogue can be built on eight propositions.

1) There are many viable pathways and styles of addiction recovery.
2) Religious experience can serve as a powerful catalyst of recovery initiation for some people (Miller & C'de Baca, 2001).
3) Religious beliefs, religious rituals, and supportive relationships within a faith community can serve as a framework of recovery maintenance.
4) Patterns of recovery pathways (religious, spiritual, secular) vary across developmental age and gender and between and within various ethnic communities.
5) The recovery and regeneration of people formally addicted to alcohol and drugs is cause for celebration, regardless of the medium of such recovery.
6) Recovery from addiction is a complex process, often involving physical, psychological, social, cultural, and ontological (e.g., the meaning of existence) dimensions.
7) Addiction recovery often requires the involvement of multiple disciplines and service practitioners, each of which is ethically mandated to practice within, and only within, the boundaries of their education, training, and experience.
8) Addiction treatment is best conducted out of respect for, and within, the cultural and religious heritage and the personal belief system that each client brings to the service environment.

Not everyone within the professional world of addiction treatment and diverse communities of recovery will agree with all of these propositions, but we believe that enough will to allow this dialogue to begin in an attitude of mutual respect and tolerance.

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Coming next: The Varieties of Secular Recovery

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www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2005) Fire in the family: Historical perspectives on the intergenerational effects of addiction. *Counselor*, 6(1), 20-25. Posted at www.williamwhitepapers.com

Fire in the Family: Historical Perspectives on the Intergenerational Effects of Addiction

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Alcoholism is a fire that has raged through my family for generations. We've all been burned. We all carry its scars. –a client

Interest in the effects of addiction on the family system and the prolonged developmental effects of children exposed to parental addiction has ebbed and flowed for nearly two centuries in America. Periods of illumination and enlightened response to addiction-affected families emerge, only to be re-engulfed by social stigma and public and professional misunderstanding and neglect. A recent essay details the history of family perspectives on addiction, tracing those perspectives from the American temperance movement, to the rise and faltering of the adult children of alcoholics (ACoA) movement and family-centered approaches to addiction treatment, to the role of family members in the New Recovery Advocacy Movement. This much briefer essay will extract from that history a few key lessons about the impact of addiction on families and family members and about lay and professional responses to families affected by addiction.

Addiction and the Family

Family adaptation to addiction distorts family roles, rules and rituals; negatively affects family subsystems (adult intimacy dyad, parent-child relationships, and sibling relationships), alters the family's relationship with the outside environment, and affects the long-term development of children exposed to parental addiction. While modern studies have added scientific credence to these assertions, such studies only confirm the realities that were first conveyed in the literature of the American temperance movement. The temperance novels of T.S. Arthur and temperance plays such as The Drunkard, One Cup More, and The Doom of the Drunkard portrayed the devastating effects of alcoholism on the family as vividly as any subsequent scientific study.

The modern understanding of the effects of alcoholism and other addictions on the family begins with the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism," and her subsequent articles on the

developmental problems experienced by children of alcoholics (Jackson, 1954, 1964). Subsequent family studies evolved through several stages of primary focus: the alcoholic wife, the alcoholic marriage, the nature of the alcoholic family as a dynamic system, the effects of alcoholism on children and adult children of alcoholics, and family therapy approaches to the treatment of a broad spectrum of substance use disorders.

Parental Addiction and Child/Adult Development

Childhood trauma resulting from parental addiction unfolds developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors. During the 1980s*, g*rowing interest in the special needs of children of alcoholics generated the concepts of "co-alcoholism" and "para-alcoholism" (Greenleaf, 1981) that were further amplified by the writings of Claudia Black and Sharon Wegscheider-Cruse. These writings graphically depicted the developmental effects of parental alcoholism on children and catalogued how these experiences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). Professional interest in and responses to the needs of children and adult children of alcoholics have ebbed and flowed since peaking in the 1980s. Greater continuity of support can be found within the arena of mutual aid groups for families impacted by addiction. Such continuity is reflected in the family support groups within the American Temperance Movement and by the progressive growth of Al-Anon and other family support structures since the mid-twentieth century.

Intergenerational Transmission

Biological vulnerability, developmental trauma and social learning interact to elevate the risk children of alcoholics face in their own relationships with alcohol and other drugs. In 1835, Robert MacNish observed that alcoholism could "descend from parents to their children" and went on to suggest that while this might result from "bad example and imitation," it was more likely a problem of "family predisposition" (p. 61).

One of the founding principles of the American Association for the Cure of Inebriety (1870) was that the disease of inebriety could be inherited or acquired. Modern research has shed considerable light on the complex etiological roots of addiction and how multiple factors interact to sustain the intergenerational transmission of alcohol and other drug problems. I envision a future in which interventions into severe alcohol and other drug problems will include a central focus on breaking intergenerational patterns of problem transmission. If achieved, that focus would mark the full integration of treatment and prevention technologies.

Addiction other than Alcoholism

T*he experiences of family members confronting alcoholism periodically break into public and professional consciousness (even in the autobiographies of our Presidents), but the experiences of family members facing other patterns of addiction have been long-cloaked in silence.* The professional literature on the latter is very meager (focusing mostly on adolescents) and is eclipsed by depictions of such experience in the non-scientific literature, e.g., Eugene O'Neil's autobiographical depiction of his mother's opiate addiction in Long Day's Journey into Night. It is important for the addiction professional to recognize that most of what we know about addiction and the family is based on studies of alcoholism and may or 0may not be applicable to other patterns of addiction and recovery.

Family Support Groups

Family support groups have provided a sanctuary of healing for family members wounded by addiction for more than 160 years. Women and children wounded by alcoholism sought shelter in a rising Temperance Movement of the 1830s. Many

women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Involvement in local temperance societies served therapeutic functions for the daughters, sisters, wives and mothers of alcoholics (Bordin, 1990). America's early recovery mutual aid societies often created auxiliary societies for wives (e.g., the Martha Washington Society founded in 1842) and created junior auxiliaries for children. These auxiliary societies flourished in the nineteenth century, dissipated in the early twentieth century and were revived via the rise of the "Alcoholics Anonymous Associates" and "Non-A.A. Groups" organized in 1951 into Al-Anon Family Groups which later (1957) spawned Alateen. Al-Anon, which currently has more than 390,000 members in 30,000 registered groups, has been widely used as a model of family support by other recovery mutual aid societies (Humphreys, 2004).

The ACoA/Codependency Movement

The ACoA / Codependency Movements illustrate how recovery mutual aid movements can be wounded by "fuzzy thinking" (over-extension of the concept of codependency) and colonized and corrupted for personal and institutional gain. The writings of Claudia Black, Sharen Wegscheider-Cruse, Janet Woititz, in the 1980s marked a significant shift, in which the alcoholic's family members were viewed, not simply as sources of support for the alcoholic's recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields—counseling children and adult children of alcoholics—and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACoA) groups were formed within Al-Anon—some 1,100 by 1986—and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995). (See sidebar for a chronology of the ACoA Movement)

In the late 1980s, the writings of Melody Beattie, John Bradshaw and others extended the concept of co-alcoholism to the concept of codependence. Codependency was defined via an ever-expanding, all-encompassing symptom checklist. Interest in co-dependence, fueled by Beattie's writings and Bradshaw's lectures on PBS, spawned Co-Dependents Anonymous, which by 1990 had more than 1,600 registered groups (Makela, et al, 1996). Responding to this wave of interest, addiction treatment programs began offering treatment tracks for persons suffering from the "disease of co-dependency" and began extending residential stays for alcoholics and addicts to address "codependency issues." This produced both an ideological backlash (biting critiques of the concept of co-dependency) (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992) and a financial backlash (erosion of treatment benefits) sparked by perceptions of profiteering within the addiction treatment industry. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that they could not provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions. Whatever original value existed within the concept of codependency was rapidly swept away amid these backlashes and will await retrieval (and probable re-christening) in the future.

Family Members as Advocates

Family members affected by addiction have historically been a potent force as they banded together to pursue broader policy issues related to the sources and solutions of alcohol and other drug problems. Such advocacy efforts span:

- the "Women's Crusade" and "Children's Crusade" of the

19th century temperance movement,
- advocacy for mandatory temperance education, drinking age laws, and state and national prohibition of alcohol,
- the local alcoholism councils of the mid-twentieth century that laid the educational and legislative foundation for modern addiction treatment,
- issues specific advocacy campaigns, e.g., MADD), and
- participation and leadership roles within the New Recovery Advocacy Movement that is spreading across the U.S..

Historically, when systems of care for addiction weaken or collapse, recovering people and their family members reorganize to address those inadequacies.

Professional Disdain for Families

Family members of those suffering from alcohol and other drug problems have historically been viewed as a cause of such problems or an obstacle to their solution. There are only brief and isolated periods in which professional treatment has been a place of welcome and refuge for addiction-affected families. From the earliest days of addiction treatment, wives of alcoholics were viewed by the staff of those institutions as hostile interlopers (An Inmate, 1869). This perception continued well into the twentieth century, where mid-century goals were not to treat the alcoholic family or involve family members in the treatment of the alcoholic, but to isolate the alcoholic and coax the family into a position of non-interference (Cutten,1907; Strecker and Chambers, 1938).

Family members, particularly mothers and wives, were also blamed for the alcoholism of their sons and husbands. Peabody (1936) viewed maternal domination as a primary cause of alcoholism, and Whalen (1944) and Futterman (1953) created crude clinical classifications of wives of alcoholics (e.g., Suffering Susan, Controlling Catherine, Wavering Winnifred, and Punishing Polly) and depicted these women as neurotic, sexually repressed, dependent, man-hating, and domineering (See Day, 1961 for a review). The typical therapist's view of the wife of the alcoholic in the mid-twentieth century was, "I'd drink, too, if I was married to her" (Reddy, 1971, p.1). These views were challenged only when scientific studies (Corder, Hendricks, & Corder, 1964) of spouses of alcoholics (mostly Al-Anon members) failed to support these characterizations.

The Short Era of "Family Programs" (1950s-1970s)

The "family programs" linked to inpatient treatment programs (1965-1985) constitute a Camelot period in the treatment industry's response to families—an era of rapid knowledge development that was aborted via the closing or dramatic restructuring of most inpatient treatment programs in the late 1980s and 1990s. There were several pioneers in the development of family-oriented alcoholism treatment models during the 1960s: Johns Hopkins Hospital, Sandstone Hospital and Hazelden and Lutheran General Hospital, the latter two having experimented with residential "family week" and "family weekend" programs (White, 1998). Family programs spread rapidly as an innovation within the "28-day rehab centers" during the 1970s and 1980s, but fell rapidly in popularity as lengths of stays were progressively shortened and third-party payors stopped paying for what they deemed "ancillary" services. Since the late 1980s, the addiction treatment field has been in a period of disengagement from families within the mainstream treatment system. (The only exception to this is the increase in family therapies for adolescent substance use disorders. See Liddle & Dakof, 1995). Programs that have continued strong family programs (e.g., Betty Ford Center) are the exception today. What these cycles of family engagement and

disengagement suggest is that family-oriented services have existed only as a weakly attached appendage to the American system of addiction treatment. The 1970s and 1980s represent a brief window of clinical progress in which the complex wounds of family members affected by addiction were recognized and treated in their own right.

The "Trauma of Recovery"

Recovery from addiction is a process that so dramatically alters family structure and process that family researchers have coined the demands of such adaptation the "trauma of recovery" (Brown, 1994). The research of Drs. Stephanie Brown and Virginia Lewis challenge the expectation that families can rapidly regain health following the initiation of addiction recovery. The chaotic family environment during addiction often continues well into the early years of recovery; recovery can destabilize family relationships; and without support, families that survived all manner of insults from addiction may disintegrate from the demands of recovery. Family research confirms the need for family-oriented models of treatment and family-focused, post-treatment monitoring and support services.

Family Disease: Rhetoric versus Clinical Practice

Professional responses to those affected by addiction evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, facilitating support groups for wives of alcoholics, conjoint marital therapy, the development of intervention to engage the addicted family member in treatment, family education programs and primary treatment for family members focused on their individual recoveries. Alcoholism/addiction has been characterized as a "family disease" since the mid-twentieth century. That rhetoric continues today, but there is little evidence that such beliefs permeate clinical practice. If we really believed that addiction was a family disease, we would not assess, treat and provide continued support services to individuals in isolation from their families. We would instead deliver family-oriented models of engagement, assessment, treatment and continuing care. The movement to develop such models in the 1970s and 1980s needs to be revitalized and sustained in the twenty-first century. Two groups must join to lead this revitalization movement: family members affected by addiction and front-line addiction professionals.

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Citation: White, W. (2005) Fire in the family: Historical perspectives on the intergenerational effects of addiction. *Counselor*, 6(1), 20-25. Posted at www.williamwhitepapers.com

Fire in the Family: Historical Perspectives on the Intergenerational Effects of Addiction

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Alcoholism is a fire that has raged through my family for generations. We've all been burned. We all carry its scars. –a client

Interest in the effects of addiction on the family system and the prolonged developmental effects of children exposed to parental addiction has ebbed and flowed for nearly two centuries in America. Periods of illumination and enlightened response to addiction-affected families emerge, only to be re-engulfed by social stigma and public and professional misunderstanding and neglect. A recent essay details the history of family perspectives on addiction, tracing those perspectives from the American temperance movement, to the rise and faltering of the adult children of alcoholics (ACoA) movement and family-centered approaches to addiction treatment, to the role of family members in the New Recovery Advocacy Movement. This much briefer essay will extract from that history a few key lessons about the impact of addiction on families and family members and about lay and professional responses to families affected by addiction.

Addiction and the Family

Family adaptation to addiction distorts family roles, rules and rituals; negatively affects family subsystems (adult intimacy dyad, parent-child relationships, and sibling relationships), alters the family's relationship with the outside environment, and affects the long-term development of children exposed to parental addiction. While modern studies have added scientific credence to these assertions, such studies only confirm the realities that were first conveyed in the literature of the American temperance movement. The temperance novels of T.S. Arthur and temperance plays such as The Drunkard, One Cup More, and The Doom of the Drunkard portrayed the devastating effects of alcoholism on the family as vividly as any subsequent scientific study.

The modern understanding of the effects of alcoholism and other addictions on the family begins with the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism," and her subsequent articles on the

developmental problems experienced by children of alcoholics (Jackson, 1954, 1964). Subsequent family studies evolved through several stages of primary focus: the alcoholic wife, the alcoholic marriage, the nature of the alcoholic family as a dynamic system, the effects of alcoholism on children and adult children of alcoholics, and family therapy approaches to the treatment of a broad spectrum of substance use disorders.

Parental Addiction and Child/Adult Development

Childhood trauma resulting from parental addiction unfolds developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors. During the 1980s*, g*rowing interest in the special needs of children of alcoholics generated the concepts of "co-alcoholism" and "para-alcoholism" (Greenleaf, 1981) that were further amplified by the writings of Claudia Black and Sharon Wegscheider-Cruse. These writings graphically depicted the developmental effects of parental alcoholism on children and catalogued how these experiences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). Professional interest in and responses to the needs of children and adult children of alcoholics have ebbed and flowed since peaking in the 1980s. Greater continuity of support can be found within the arena of mutual aid groups for families impacted by addiction. Such continuity is reflected in the family support groups within the American Temperance Movement and by the progressive growth of Al-Anon and other family support structures since the mid-twentieth century.

Intergenerational Transmission

Biological vulnerability, developmental trauma and social learning interact to elevate the risk children of alcoholics face in their own relationships with alcohol and other drugs. In 1835, Robert MacNish observed that alcoholism could "descend from parents to their children" and went on to suggest that while this might result from "bad example and imitation," it was more likely a problem of "family predisposition" (p. 61).

One of the founding principles of the American Association for the Cure of Inebriety (1870) was that the disease of inebriety could be inherited or acquired. Modern research has shed considerable light on the complex etiological roots of addiction and how multiple factors interact to sustain the intergenerational transmission of alcohol and other drug problems. I envision a future in which interventions into severe alcohol and other drug problems will include a central focus on breaking intergenerational patterns of problem transmission. If achieved, that focus would mark the full integration of treatment and prevention technologies.

Addiction other than Alcoholism

T*he experiences of family members confronting alcoholism periodically break into public and professional consciousness (even in the autobiographies of our Presidents), but the experiences of family members facing other patterns of addiction have been long-cloaked in silence.* The professional literature on the latter is very meager (focusing mostly on adolescents) and is eclipsed by depictions of such experience in the non-scientific literature, e.g., Eugene O'Neil's autobiographical depiction of his mother's opiate addiction in Long Day's Journey into Night. It is important for the addiction professional to recognize that most of what we know about addiction and the family is based on studies of alcoholism and may or 0may not be applicable to other patterns of addiction and recovery.

Family Support Groups

Family support groups have provided a sanctuary of healing for family members wounded by addiction for more than 160 years. Women and children wounded by alcoholism sought shelter in a rising Temperance Movement of the 1830s. Many

women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Involvement in local temperance societies served therapeutic functions for the daughters, sisters, wives and mothers of alcoholics (Bordin, 1990). America's early recovery mutual aid societies often created auxiliary societies for wives (e.g., the Martha Washington Society founded in 1842) and created junior auxiliaries for children. These auxiliary societies flourished in the nineteenth century, dissipated in the early twentieth century and were revived via the rise of the "Alcoholics Anonymous Associates" and "Non-A.A. Groups" organized in 1951 into Al-Anon Family Groups which later (1957) spawned Alateen. Al-Anon, which currently has more than 390,000 members in 30,000 registered groups, has been widely used as a model of family support by other recovery mutual aid societies (Humphreys, 2004).

The ACoA/Codependency Movement

The ACoA / Codependency Movements illustrate how recovery mutual aid movements can be wounded by "fuzzy thinking" (over-extension of the concept of codependency) and colonized and corrupted for personal and institutional gain. The writings of Claudia Black, Sharen Wegscheider-Cruse, Janet Woititz, in the 1980s marked a significant shift, in which the alcoholic's family members were viewed, not simply as sources of support for the alcoholic's recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields—counseling children and adult children of alcoholics—and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACoA) groups were formed within Al-Anon—some 1,100 by 1986—and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995). (See sidebar for a chronology of the ACoA Movement)

In the late 1980s, the writings of Melody Beattie, John Bradshaw and others extended the concept of co-alcoholism to the concept of codependence. Codependency was defined via an ever-expanding, all-encompassing symptom checklist. Interest in co-dependence, fueled by Beattie's writings and Bradshaw's lectures on PBS, spawned Co-Dependents Anonymous, which by 1990 had more than 1,600 registered groups (Makela, et al, 1996). Responding to this wave of interest, addiction treatment programs began offering treatment tracks for persons suffering from the "disease of co-dependency" and began extending residential stays for alcoholics and addicts to address "codependency issues." This produced both an ideological backlash (biting critiques of the concept of co-dependency) (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992) and a financial backlash (erosion of treatment benefits) sparked by perceptions of profiteering within the addiction treatment industry. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that they could not provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions. Whatever original value existed within the concept of codependency was rapidly swept away amid these backlashes and will await retrieval (and probable re-christening) in the future.

Family Members as Advocates

Family members affected by addiction have historically been a potent force as they banded together to pursue broader policy issues related to the sources and solutions of alcohol and other drug problems. Such advocacy efforts span:

- the "Women's Crusade" and "Children's Crusade" of the

19th century temperance movement,
- advocacy for mandatory temperance education, drinking age laws, and state and national prohibition of alcohol,
- the local alcoholism councils of the mid-twentieth century that laid the educational and legislative foundation for modern addiction treatment,
- issues specific advocacy campaigns, e.g., MADD), and
- participation and leadership roles within the New Recovery Advocacy Movement that is spreading across the U.S..

Historically, when systems of care for addiction weaken or collapse, recovering people and their family members reorganize to address those inadequacies.

Professional Disdain for Families

Family members of those suffering from alcohol and other drug problems have historically been viewed as a cause of such problems or an obstacle to their solution. There are only brief and isolated periods in which professional treatment has been a place of welcome and refuge for addiction-affected families. From the earliest days of addiction treatment, wives of alcoholics were viewed by the staff of those institutions as hostile interlopers (An Inmate, 1869). This perception continued well into the twentieth century, where mid-century goals were not to treat the alcoholic family or involve family members in the treatment of the alcoholic, but to isolate the alcoholic and coax the family into a position of non-interference (Cutten,1907; Strecker and Chambers, 1938).

Family members, particularly mothers and wives, were also blamed for the alcoholism of their sons and husbands. Peabody (1936) viewed maternal domination as a primary cause of alcoholism, and Whalen (1944) and Futterman (1953) created crude clinical classifications of wives of alcoholics (e.g., Suffering Susan, Controlling Catherine, Wavering Winnifred, and Punishing Polly) and depicted these women as neurotic, sexually repressed, dependent, man-hating, and domineering (See Day, 1961 for a review). The typical therapist's view of the wife of the alcoholic in the mid-twentieth century was, "I'd drink, too, if I was married to her" (Reddy, 1971, p.1). These views were challenged only when scientific studies (Corder, Hendricks, & Corder, 1964) of spouses of alcoholics (mostly Al-Anon members) failed to support these characterizations.

The Short Era of "Family Programs" (1950s-1970s)

The "family programs" linked to inpatient treatment programs (1965-1985) constitute a Camelot period in the treatment industry's response to families—an era of rapid knowledge development that was aborted via the closing or dramatic restructuring of most inpatient treatment programs in the late 1980s and 1990s. There were several pioneers in the development of family-oriented alcoholism treatment models during the 1960s: Johns Hopkins Hospital, Sandstone Hospital and Hazelden and Lutheran General Hospital, the latter two having experimented with residential "family week" and "family weekend" programs (White, 1998). Family programs spread rapidly as an innovation within the "28-day rehab centers" during the 1970s and 1980s, but fell rapidly in popularity as lengths of stays were progressively shortened and third-party payors stopped paying for what they deemed "ancillary" services. Since the late 1980s, the addiction treatment field has been in a period of disengagement from families within the mainstream treatment system. (The only exception to this is the increase in family therapies for adolescent substance use disorders. See Liddle & Dakof, 1995). Programs that have continued strong family programs (e.g., Betty Ford Center) are the exception today. What these cycles of family engagement and

disengagement suggest is that family-oriented services have existed only as a weakly attached appendage to the American system of addiction treatment. The 1970s and 1980s represent a brief window of clinical progress in which the complex wounds of family members affected by addiction were recognized and treated in their own right.

The "Trauma of Recovery"

Recovery from addiction is a process that so dramatically alters family structure and process that family researchers have coined the demands of such adaptation the "trauma of recovery" (Brown, 1994). The research of Drs. Stephanie Brown and Virginia Lewis challenge the expectation that families can rapidly regain health following the initiation of addiction recovery. The chaotic family environment during addiction often continues well into the early years of recovery; recovery can destabilize family relationships; and without support, families that survived all manner of insults from addiction may disintegrate from the demands of recovery. Family research confirms the need for family-oriented models of treatment and family-focused, post-treatment monitoring and support services.

Family Disease: Rhetoric versus Clinical Practice

Professional responses to those affected by addiction evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, facilitating support groups for wives of alcoholics, conjoint marital therapy, the development of intervention to engage the addicted family member in treatment, family education programs and primary treatment for family members focused on their individual recoveries. Alcoholism/addiction has been characterized as a "family disease" since the mid-twentieth century. That rhetoric continues today, but there is little evidence that such beliefs permeate clinical practice. If we really believed that addiction was a family disease, we would not assess, treat and provide continued support services to individuals in isolation from their families. We would instead deliver family-oriented models of engagement, assessment, treatment and continuing care. The movement to develop such models in the 1970s and 1980s needs to be revitalized and sustained in the twenty-first century. Two groups must join to lead this revitalization movement: family members affected by addiction and front-line addiction professionals.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2005) Recovery: Its history and renaissance as an organizing construct. Alcoholism Treatment Quarterly, 23(1), 3-15. Posted at **www.williamwhitepapers.com**

Recovery:
Its History and Renaissance as an Organizing Construct Concerning Alcohol and Other Drug Problems

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Abstract

Characterizing the resolution of severe alcohol and other drug problems in moral (reformation), religious (redemption), psychological (reconstruction), criminal (rehabilitation), or medical (recovery, remission) language reflects larger conceptualizations of the sources, solutions and claims for institutional ownership of alcohol and other drug problems. This article traces the history of the concept of recovery in America as applied to alcohol and other drug problems and describes the addiction field's evolution through problem (pathology) and intervention (treatment) paradigms to the call for a recovery paradigm as its central "governing image."

Key words: addiction recovery, recovery advocacy, recovery paradigm, history

Recovery: Its History and Renaissance as an Organizing Concept

Professional fields are often birthed to meet the needs of a culture at a particular point in time. Their survival or extinction depends to a great extent on how well the profession and its institutions are able to evolve from a problem paradigm (defining the problem in a way that creates and sustains the profession claim to cultural ownership of the problem) through an intervention paradigm (developing, institutionalizing and refining problem resolution technologies with perceived effectiveness and value) to a solution paradigm (achieving sustainable, visible proof that the problem definitions and proffered technologies "work"). These evolving organizing models reflect what Room (2001) has characterized as "governing images" within the alcohol and other drug (AOD) problems arena. Governing images are concepts that imply particular frameworks of problem definition, intervention and resolution. In an earlier essay (White, 2004a), the author

described the evolution of the addictions field's conceptual center from a focus on pathology (the study of AOD problems as medical diseases) to treatment (medical/psychiatric/psychological interventions into AOD problems) to recovery (prospects and processes for long-term resolution of AOD problems). This essay elaborates on this proposition by describing the history of the concept of recovery and the call to make recovery the "governing image" of a maturing addictions field.

The Discovery of Recovery

A dramatic rise in alcohol consumption in the late 18th and early 19th centuries led to a shift from moral/religious/legal conceptualizations to medical conceptualizations of chronic drunkenness—a shift that was subsequently applied to the chronic use of opium, morphine, and cocaine. This "discovery of addiction" (Levine, 1978) led to new ways of characterizing alcohol and other drug-related problems and the processes through which such problems could be resolved. The intemperate drunkard became first the inebriate, then the dipsomaniac, and then the alcoholic/addict. The source of alcohol problems shifted from moral character to the disease processes of inebriety, dipsomania, alcoholism, and addiction. The perception of chronic drunkenness shifted from a characterologically-rooted assertion of volitional choice (a bad person choosing to do bad things) to a biologically-rooted disease of the will (a good person doing bad things over which he or she has limited volitional control). The perception of the solution to these problems at an individual level shifted from vice and reformation (moral model) to sin and redemption (religious model) to sickness and recovery (medical model).

The roots of the medical model can be traced to a social reformer (Anthony Benezet, 1774), a physician (Benjamin Rush, 1784) and a member of the clergy (Lyman Beecher, 1827). In this new medicalized view, chronic drunkenness was defined as a medical disorder (an "odious disease" that "resembles certain hereditary, family and contagious disease") (Rush, 1784, p. 8). The word *cure,* rather than *recovery,* was initially applied to the resolution of drunkenness as it was similarly applied to the reversal of other disorders of health. Optimism about cure was inherent in Benjamin Rush's early call to create special institutions for the care of the inebriate (Rush, 1810). Where *cure* placed the center of focus on the medical professional, the term recovery both extended the time frame involved and shifted the focus to the actions and experience of the person making the transition from chronic drunkenness to stable sobriety. Dr. Samuel Woodward made one of the earliest references to the term *recovery* as applied to addiction when he called for the creation of inebriate asylums.

> *God forbid that we should erect asylums for our own children! But God forbid, if our own children become drunkards, that they should fail to find asylums for seclusion and recovery!* (Woodward, 1836, p. 29)

Three years earlier, Gerrit Smith (Sigorney and Smith, 1833) had penned an essay entitled "Reformation of the Intemperate" in which he described thirty-eight cases of *reformed* drunkards. Smith noted the public sentiment that the drunkard was beyond *cure*, but provided evidence of the permanent "reformation of intemperate persons." The

transition from Smith's "reformation" to Woodward's "recovery" marks a significant shift from moral to medical frameworks of understanding the source and solution to severe and persistent alcohol problems.

Sobriety-based and moderation-based mutual support groups flourished in the mid-nineteenth century, but nearly all of these groups—the Washingtonians, the fraternal temperance societies, the ribbon reform clubs, the Businessmen's Moderation Society—viewed the personal solution to drunkenness as a process of moral and religious reformation achieved through public commitment to sobriety or restricted consumption (pledge signing), mutual surveillance and support, and rescue work with other drunkards. The "drunkards tales" (alcoholic biographies and autobiographies) of this era characterize the transition from chronic drunkenness to stable sobriety using a variety of terms: "reformation," "restoration" (of body, mind and social position), "redemption," "repentance," "rebirth," "resurrection," "rescue and deliverance," and "liberation" (see Gale, 1842; Woodman, 1843; Green, 1849; Gough, 1870; Berry, 1871; McKenzie, 1875).

There was an emerging consciousness that achieving sobriety following chronic drunkenness was an on-going process rather than point-in-time "pledge of perpetual hate to all that can intoxicate" (Gale, 1842). This process came to be understood as something more than a renunciation of alcohol and a sobriety resolution. Harrison reported in 1860 that the Washingtonian Society of Boston "fitted up rooms under their hall for the temporary accommodation of reformed, or rather, reforming, men". The debate over whether abstinent alcoholics were *recovered* or were *recovering* had begun. A portion of this debate emerged from the growing realization that recovery required and involved more than the absence of drinking. McKenzie declared in 1876 that, "The only safety for men who have once yielded to their appetite for drink, is in a change of heart, involving a complete change of life." While the terms *recovery* and *recovered* appear a few times in this literature (e.g., McKenzie, 1876, p. 94), their use generally refers to the brief period of physical convalescence following an acute drinking episode rather than the broader and more sustained resolution of addiction to alcohol. There are only occasional references to a larger understanding of an inebriate having "recovered from their [distilled spirits or intemperate habits] power" (Gale, 1842, p. 75).

As inebriate homes and asylums spread between 1860 and the end of the 19th century, the nation's first inebriety specialists viewed inebriety as a disease and used the term *recovery* to depict the inebriate's return to health. Dr. Albert Day in his 1867 text, *Methomania*, spoke not only of recovery for his patients, but even suggested the concept of "partial recovery"—dramatic improvements in the functioning of chronic drunkards who had yet to achieve sustained abstinence (Day, 1867, p. 33). Dr. Robert Parrish, the driving force behind the founding of the American Association for the Cure of Inebriety, similarly spoke of "recovery from a life of inebriation to a life of sobriety" and noted the ability of some inebriates to "recover naturally, that is of their own unaided efforts" (Parrish, 1886, pp.84, 126) Parrish went on to describe recovery as an enduring process that required what today would be called relapse prevention.

> *The paroxysms may be arrested, prevented, or controlled, by becoming familiar with the prodromic symptoms, and giving timely heed to their admonitions by the use of remedial measures. (Parrish, 1886, p. 181)*

Pioneers like Parrish did not view the transition from perpetual drunkenness to enduring sobriety as a moral decision (pledge signing) or as an outcome of religious experience (conversion, redemption). They instead viewed recovery as a sustained process requiring both medical supervision and the inebriate's active and sustained participation in his or her own convalescence. These first addiction medicine specialists called for the quarantine of the inebriate where "he could be treated for his malady until he recovered" (Crothers, 1893). In their view, the disease of inebriety proceeded "either to recovery or death" (Willet, 1877, p. 14). The literature of the inebriety treatment movement sustained its proposition that intemperance was a disease but vacillated between references to cure and references to recovery, with the latter eventually replacing the former (Proceedings, 1870-1875).

Recovery: Lost and Found

Most inebriate homes and asylums and recovery mutual aid societies collapsed during the opening decades of the twentieth century. The medicalization of alcohol problems faded in a wave of pessimism about the prospects of long-term recovery from alcohol and other drug addiction (White, 1998). The alcoholic was again seen as incorrigible, and the solution to drunkenness shifted from personal reformation or rebirth to depriving the present and future drunkards' legal access to alcohol. In the wake of growing stigma attached to alcoholism, a new generation of addiction specialists tried to explain that hope for recovery would be poor for any disease that came under treatment so late. They argued that good recovery rates were possible but only if treatment was provided earlier in the course of alcoholism (Cooper, 1913, p. 97). But amidst the rising stigma of alcoholism and the drives for county, state and then federal Prohibition, professional advocacy for treatment and recovery waned and the public voices of recovering people fell silent.

A psychotherapy clinic established at the Emmanuel Church in Boston in 1906 marked a pocket of continued hope for recovery from alcoholism. The clinic, which integrated medicine, religion, and psychology in the treatment of alcoholism, trained lay therapists who had been successfully treated for alcoholism at the clinic. Courtenay Baylor, the first of the Boston lay therapists, described this resolution of alcoholism in terms of "recovery" and "reconstruction"--the latter referring to fundamental changes that had to occur in the alcoholic's personality (Baylor, 1919, p. 38). Richard Peabody, the most famous of the lay therapists, later abandoned the concept of recovery, embracing instead a demedicalized view of the source and solution to alcoholism. Peabody saw alcoholism not as a disease of the body but as a "disease of immaturity" that required the alcoholic (who Peabody characterized as a "spoiled child"), not to recover, but to grow up via a reconstruction of personal character. When this moral and psychological reconstruction had occurred, the alcoholic was viewed not in a state of continuing recovery but as a person who had "rid himself of his habit once and for all"—"an ex-alcoholic" (Peabody, 1933, pp. 170-171,187). The Emmanuel Clinic was joined by a new generation of private hospitals and sanatoria that boasted of their abilities to treat alcoholism. For a brief time, the concept of *cure* again competed with the concept of *recovery*.

The founding of Alcoholics Anonymous (AA) in 1935 marked the re-emergence of *recovery* as a word and concept centrally linked to the resolution of alcoholism. The first (1939) edition of AA's basic text contained more references to *recovery* than any previous text, using the term *recovery* in the book's subtitle (*The Story of How More Than One Hundred Men Have Recovered from Alcoholism*) and proclaiming its purpose to describe "PRECISELY HOW WE HAVE RECOVERED" (caps in original text). Various forms of the word *recovery* appear more than 70 times in the first edition of AA's "Big Book" (Alcoholics Anonymous, 1939).

AA portrayed the resolution of alcoholism not as a decision or an event but an enduring process. It is with AA that we see the movement of *recovery* from a peripheral to a central, organizing construct. Prior to AA, the word *recovery* tended to imply the extended convalescence often required to reverse the physical ravages of alcoholism. It is in AA that we find the term used as the central concept depicting the ongoing cognitive, emotional, behavioral and spiritual reconstruction of the sobered alcoholic. Also significant was AA's shift in emphasis from recovery initiation (how to stop drinking) to recovery maintenance (how to not start drinking) and from chemical sobriety to "emotional sobriety" (Wilson, 1945). Positive coverage of AA by the American press in the mid-twentieth century stirred a resurgence of faith in the prospects that at least some alcoholics could permanently stop drinking. AA declared in the first edition of its basic text: "We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition" (AA, 1939, pp 104-105). The focus had shifted again from cure to recovery as a time-extended and multi-dimensional process.

Recovery, Treatment, and Backlash

Alcoholics Anonymous was part of a larger "modern alcoholism movement" that between 1935 and 1970 redefined America's conception of alcoholism and the alcoholic (Johnson, 1973; Roizen, 1991). The centerpiece of the modern alcoholism movement was a set of "kinetic ideas" that focused on the nature of alcoholism ("is a disease") and the alcoholic ("can be helped" and "is worthy of help") (Anderson, 1942; Mann, 1944). Through the efforts of the National Committee for Education on Alcoholism (the precursor to today's National Council on Alcoholism and Drug Dependence), the federal, state and local investment in alcoholism education and treatment expanded with a fully developed alcoholism field emerging in the 1970s. Public support for alcoholism treatment rose as Americans came to see alcoholism in medical rather than moral terms and as the popular image of the alcoholic shifted from that of the "Skid Row" wino to that of a family member, friend, neighbor or co-worker. Recovery also became more visible as many prominent Americans publicly declared their recovery from alcoholism in the late 1970s.

The eventual fruits of the modern alcoholism movement included a multi-billion dollar treatment industry; a broadened conceptual and institutional scope from alcoholism to chemical dependency, substance abuse, and addiction; the extension of the latter into the realm of "process addictions" (excessive and harmful relationships with people, work, money, gambling); and a shift in focus from the nature of AOD problems to the availability of effective interventions ("Treatment Works"). All were embraced within an amorphous, highly commercialized "recovery movement" that became something of a cultural phenomenon in the late 1980s and 1990s (White, 1998), with one social commentator referring to it as "recovery fever" (Blau, 1991). This phenomenon was marked by an explosive growth of Alcoholics Anonymous, the adaptation of AA to virtually every human problem, a recovery publishing boon, and an unending parade of celebrities entering and returning from "rehab."

The brief super-success of the recovery movement was followed in the 1990s by a backlash to this movement. The backlash took many forms, including attacks on the medicalized concept of addiction (Davies, 1997; Schaler, 2000), criticisms of the conceptualization of addiction as a disease (Fingarette, 1989; Peele, 1989); and challenges to the related concept of co-dependency (Kaminer, 1992; Katz and Liu, 1991). There were also sustained attacks on

addiction treatment (Peele and Brodsky, 1991) and on Alcoholics Anonymous and other Twelve Step programs (Bufe, 1991; Ragge, 1998; Peele and Bufe, 2000). There were financial backlashes against the treatment industry in the form of an aggressive system of managed care that led to the downsizing or closure of many hospital-based and private addiction treatment programs. These ideological and financial backlashes unfolded within the larger restigmatization, demedicalization and recriminalization of AOD problems during the 1980s and 1990s (White, 2000).

A Recovery Renaissance

In the wake of ideological and financial backlashes against the ill-defined and highly commercialized "recovery movement" (Kurtz, 1995), there is an emerging recovery renaissance within the alcohol and other drug problems arena.

In the sphere of recovery mutual aid, there are increasing varieties of Twelve Step experience (Kurtz and White, 2003), increasing numbers of adjuncts and alternatives to Twelve Step programs (Humphreys, 2004; White, 2004b), and a growing celebration of the diversity of American communities of recovery (White, 2000, 2002).

At national policy levels, this focused attention on recovery is evident in:

- President Bush's Access to Recovery Initiative which expands funding for recovery support services, broadens the range of agencies who can provide such services, and increases consumer choice in selecting providers of recovery support services (http://www.whitehousedrugpolicy.gov/treat/initiative.html).
- the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse's growing interest in the biological foundations of recovery, patterns and styles of long-term recovery, and development of new, post-detoxification, pharmacological aids to recovery.
- the Center for Substance Abuse Treatment's Recovery Community Support Program (http://www.treatment.org/Topics/archive/rcsp.htm) which has sought to involve recovering people and their families and allies in the enhancement of treatment and recovery support services, and Recovery Month activities which have promoted recovery-themed public education and recovery celebratory events (http://www.recoverymonth.gov/2002/links.htm).
- private foundation support for recovery-focused treatment system enhancements, e.g., Robert Wood Johnson's $9.5 million Paths to Recovery Initiative to enhance addiction treatment access and retention (http://www.pathstorecovery.org/)

There are also national efforts to survey the "recovery community" (Road to Recovery, 1998) and mobilize recovering people and their families into a "new recovery advocacy movement" (White, 2000). This movement is visible at a national level through the Faces and Voices of Recovery Campaign (www.facesandvoicesofrecovery.org) and is visible at state and local levels through the growing network of recovery advocacy organizations (e.g., www.ccar.org), a vibrant "wellbriety movement" in Indian Country (Coyhis, 1999; see www.whitebison.org), and the growth of faith-based recovery ministries, especially in communities of color (Sanders, 2002). Collectively these groups are pushing for recovery representation at AOD-related policy tables, recovery-focused community needs assessment processes, and the development of a full continua of local treatment and recovery support services (White, 2000).

Within the treatment arena, there is also a renewed recovery focus. There are calls to get treatment reconnected to the larger and more enduring process of recovery and to shift the focus of treatment from initiating recovery in the institutional environment to anchoring recovery within

the client's natural environment (White, 2002). There are calls to shift addiction treatment from an acute model of care (assess, admit, treat, discharge) to a model of long-term recovery management (RM) (White, Boyle, and Loveland, 2002; Edwards, Davis, and Savva, 2003; Moore and Budney, 2003). The (RM) model parallels approaches used in the treatment of other health disorders characterized by chronicity, course variability, and functional fluidity (McLellan, Lewis, O'Brien and Kleber, 2000; Dennis, Scott and Funk, 2003). There are also increased experiments with "peer-oriented recovery support services", recovery-focused service roles (recovery coaches/mentors/guides), and expanded recovery support structures (self-directed recovery homes) (Jason, et al, 2001).

In the arena of clinical research, there are researchers (e.g., Keith Humphreys, Alexandre Laudet) specializing in the study of recovery support groups, as well as calls for a recovery research agenda (White, 2000; Edwards, Davis, and Savva, 2003), increased meetings between researchers and recovery advocates, and significant new studies of post-treatment monitoring and recovery support services (Godley, Godley, Dennis, Funk & Passetti, 2002; Dennis, Scott and Funk, 2003).

A New Recovery Paradigm

This emergence of the recovery concept as a governing image for the field could be simply a passing fad or it could mark a major shift in the central organizing constructs that have shaped American responses to AOD problems. I have argued (White, 2004a) that this renaissance of interest in recovery is the latter. The pathology paradigm has focused on the nature of AOD problems and the nature of individual vulnerability to such problems. It has been based on the assumption that discovering the sources of AOD problems will provide keys to their resolution. Work within this paradigm has deeply enriched our understanding of addiction and has led to many refinements in the treatment of substance use disorders. The intervention paradigm has focused on methods and strategies of resolving AOD problems. This paradigm has been based on the assumption that the evaluation of active responses to AOD problems (whether at social policy levels or through individual-focused early intervention and treatment programs) will result in evidence-based solutions to these problems. The cumulative work within this paradigm has revealed both the benefits and limitations of addiction treatment as it is currently delivered in the United States. Recovery advocates and their professional allies within the treatment and research arenas are calling upon America and the addictions field to move beyond it central focus on AOD problems and their treatment to a more fully developed recovery paradigm. The assumption is that enduring solutions already exist to AOD problems in the lives of hundreds of thousands of individuals and families and in many communities and that a greater understanding of these individuals, families and communities will reveal more global solutions to AOD problem.

Advocates of the emerging recovery paradigm are calling upon treatment agencies and personnel to become more knowledgeable of, and involved within, local communities of recovery. They are pushing treatment programs to shift their focus from acute interventions to models of long-term recovery support services. Recovery advocates are calling for an intensification of pre-treatment recovery support services that strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, determine whether the individual/family can initiate and sustain recovery without formal, professionally-directed treatment services, or link the individual/family to the most appropriate treatment services. This recovery paradigm also suggests an intensification of in-treatment recovery support services to enhance treatment retention and enhance transfer of learning from institutional to natural environments. It is altering the nature and duration of the traditional service relationship. And it is shifting the focus of treatment from acute stabilization to post-treatment recovery management, e.g., post-stabilization monitoring (recovery check-ups), stage-

appropriate recovery education, recovery coaching, active linkage to communities of recovery, recovery community resource development, and early re-intervention. Creating recovery-oriented systems of care will require a reconceptualization of the continuum of care, changes in the selection and training of care providers and a reformulation of systems of service reimbursement. Some states (e.g., Connecticut and Arizona) have formally begun this process.

The concept of recovery as a governing image has had a long birth and a stormy adolescence but is poised to emerge as the central organizing construct within the addictions field. That emergence represents not so much an alternative to the pathology and treatment paradigms as a developmental extension of these earlier paradigms. That said, the recovery paradigm could dramatically alter the future of addiction treatment and broader responses to AOD problems in America.

Acknowledgement: Support for this article was provided by grants from the National Institute on Drug Abuse (Grant R01 DA15523 and Grant R03 DA13432) and the Illinois Department of Human Services (Office of Alcoholism and Substance Abuse Services) via the Behavioral Health Recovery Management project. The opinions expressed here are those of the author and do not reflect the opinions or policies of these agencies. The author would like to express appreciation to Mike Boyle, Mike Dennis and Chris Scott for their helpful comments on an early draft of this article.

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Citation: White, W. (2005) Recovery: Its history and renaissance as an organizing construct. Alcoholism Treatment Quarterly, 23(1), 3-15. Posted at **www.williamwhitepapers.com**

Recovery:
Its History and Renaissance as an Organizing Construct Concerning Alcohol and Other Drug Problems

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Abstract

Characterizing the resolution of severe alcohol and other drug problems in moral (reformation), religious (redemption), psychological (reconstruction), criminal (rehabilitation), or medical (recovery, remission) language reflects larger conceptualizations of the sources, solutions and claims for institutional ownership of alcohol and other drug problems. This article traces the history of the concept of recovery in America as applied to alcohol and other drug problems and describes the addiction field's evolution through problem (pathology) and intervention (treatment) paradigms to the call for a recovery paradigm as its central "governing image."

Key words: addiction recovery, recovery advocacy, recovery paradigm, history

Recovery: Its History and Renaissance as an Organizing Concept

Professional fields are often birthed to meet the needs of a culture at a particular point in time. Their survival or extinction depends to a great extent on how well the profession and its institutions are able to evolve from a problem paradigm (defining the problem in a way that creates and sustains the profession claim to cultural ownership of the problem) through an intervention paradigm (developing, institutionalizing and refining problem resolution technologies with perceived effectiveness and value) to a solution paradigm (achieving sustainable, visible proof that the problem definitions and proffered technologies "work"). These evolving organizing models reflect what Room (2001) has characterized as "governing images" within the alcohol and other drug (AOD) problems arena. Governing images are concepts that imply particular frameworks of problem definition, intervention and resolution. In an earlier essay (White, 2004a), the author

described the evolution of the addictions field's conceptual center from a focus on pathology (the study of AOD problems as medical diseases) to treatment (medical/psychiatric/psychological interventions into AOD problems) to recovery (prospects and processes for long-term resolution of AOD problems). This essay elaborates on this proposition by describing the history of the concept of recovery and the call to make recovery the "governing image" of a maturing addictions field.

The Discovery of Recovery

A dramatic rise in alcohol consumption in the late 18th and early 19th centuries led to a shift from moral/religious/legal conceptualizations to medical conceptualizations of chronic drunkenness—a shift that was subsequently applied to the chronic use of opium, morphine, and cocaine. This "discovery of addiction" (Levine, 1978) led to new ways of characterizing alcohol and other drug-related problems and the processes through which such problems could be resolved. The intemperate drunkard became first the inebriate, then the dipsomaniac, and then the alcoholic/addict. The source of alcohol problems shifted from moral character to the disease processes of inebriety, dipsomania, alcoholism, and addiction. The perception of chronic drunkenness shifted from a characterologically-rooted assertion of volitional choice (a bad person choosing to do bad things) to a biologically-rooted disease of the will (a good person doing bad things over which he or she has limited volitional control). The perception of the solution to these problems at an individual level shifted from vice and reformation (moral model) to sin and redemption (religious model) to sickness and recovery (medical model).

The roots of the medical model can be traced to a social reformer (Anthony Benezet, 1774), a physician (Benjamin Rush, 1784) and a member of the clergy (Lyman Beecher, 1827). In this new medicalized view, chronic drunkenness was defined as a medical disorder (an "odious disease" that "resembles certain hereditary, family and contagious disease") (Rush, 1784, p. 8). The word *cure,* rather than *recovery,* was initially applied to the resolution of drunkenness as it was similarly applied to the reversal of other disorders of health. Optimism about cure was inherent in Benjamin Rush's early call to create special institutions for the care of the inebriate (Rush, 1810). Where *cure* placed the center of focus on the medical professional, the term recovery both extended the time frame involved and shifted the focus to the actions and experience of the person making the transition from chronic drunkenness to stable sobriety. Dr. Samuel Woodward made one of the earliest references to the term *recovery* as applied to addiction when he called for the creation of inebriate asylums.

> *God forbid that we should erect asylums for our own children! But God forbid, if our own children become drunkards, that they should fail to find asylums for seclusion and recovery!* (Woodward, 1836, p. 29)

Three years earlier, Gerrit Smith (Sigorney and Smith, 1833) had penned an essay entitled "Reformation of the Intemperate" in which he described thirty-eight cases of *reformed* drunkards. Smith noted the public sentiment that the drunkard was beyond *cure*, but provided evidence of the permanent "reformation of intemperate persons." The

transition from Smith's "reformation" to Woodward's "recovery" marks a significant shift from moral to medical frameworks of understanding the source and solution to severe and persistent alcohol problems.

Sobriety-based and moderation-based mutual support groups flourished in the mid-nineteenth century, but nearly all of these groups—the Washingtonians, the fraternal temperance societies, the ribbon reform clubs, the Businessmen's Moderation Society—viewed the personal solution to drunkenness as a process of moral and religious reformation achieved through public commitment to sobriety or restricted consumption (pledge signing), mutual surveillance and support, and rescue work with other drunkards. The "drunkards tales" (alcoholic biographies and autobiographies) of this era characterize the transition from chronic drunkenness to stable sobriety using a variety of terms: "reformation," "restoration" (of body, mind and social position), "redemption," "repentance," "rebirth," "resurrection," "rescue and deliverance," and "liberation" (see Gale, 1842; Woodman, 1843; Green, 1849; Gough, 1870; Berry, 1871; McKenzie, 1875).

There was an emerging consciousness that achieving sobriety following chronic drunkenness was an on-going process rather than point-in-time "pledge of perpetual hate to all that can intoxicate" (Gale, 1842). This process came to be understood as something more than a renunciation of alcohol and a sobriety resolution. Harrison reported in 1860 that the Washingtonian Society of Boston "fitted up rooms under their hall for the temporary accommodation of reformed, or rather, reforming, men". The debate over whether abstinent alcoholics were *recovered* or were *recovering* had begun. A portion of this debate emerged from the growing realization that recovery required and involved more than the absence of drinking. McKenzie declared in 1876 that, "The only safety for men who have once yielded to their appetite for drink, is in a change of heart, involving a complete change of life." While the terms *recovery* and *recovered* appear a few times in this literature (e.g., McKenzie, 1876, p. 94), their use generally refers to the brief period of physical convalescence following an acute drinking episode rather than the broader and more sustained resolution of addiction to alcohol. There are only occasional references to a larger understanding of an inebriate having "recovered from their [distilled spirits or intemperate habits] power" (Gale, 1842, p. 75).

As inebriate homes and asylums spread between 1860 and the end of the 19th century, the nation's first inebriety specialists viewed inebriety as a disease and used the term *recovery* to depict the inebriate's return to health. Dr. Albert Day in his 1867 text, *Methomania*, spoke not only of recovery for his patients, but even suggested the concept of "partial recovery"—dramatic improvements in the functioning of chronic drunkards who had yet to achieve sustained abstinence (Day, 1867, p. 33). Dr. Robert Parrish, the driving force behind the founding of the American Association for the Cure of Inebriety, similarly spoke of "recovery from a life of inebriation to a life of sobriety" and noted the ability of some inebriates to "recover naturally, that is of their own unaided efforts" (Parrish, 1886, pp.84, 126) Parrish went on to describe recovery as an enduring process that required what today would be called relapse prevention.

> *The paroxysms may be arrested, prevented, or controlled, by becoming familiar with the prodromic symptoms, and giving timely heed to their admonitions by the use of remedial measures. (Parrish, 1886, p. 181)*

Pioneers like Parrish did not view the transition from perpetual drunkenness to enduring sobriety as a moral decision (pledge signing) or as an outcome of religious experience (conversion, redemption). They instead viewed recovery as a sustained process requiring both medical supervision and the inebriate's active and sustained participation in his or her own convalescence. These first addiction medicine specialists called for the quarantine of the inebriate where "he could be treated for his malady until he recovered" (Crothers, 1893). In their view, the disease of inebriety proceeded "either to recovery or death" (Willet, 1877, p. 14). The literature of the inebriety treatment movement sustained its proposition that intemperance was a disease but vacillated between references to cure and references to recovery, with the latter eventually replacing the former (Proceedings, 1870-1875).

Recovery: Lost and Found

Most inebriate homes and asylums and recovery mutual aid societies collapsed during the opening decades of the twentieth century. The medicalization of alcohol problems faded in a wave of pessimism about the prospects of long-term recovery from alcohol and other drug addiction (White, 1998). The alcoholic was again seen as incorrigible, and the solution to drunkenness shifted from personal reformation or rebirth to depriving the present and future drunkards' legal access to alcohol. In the wake of growing stigma attached to alcoholism, a new generation of addiction specialists tried to explain that hope for recovery would be poor for any disease that came under treatment so late. They argued that good recovery rates were possible but only if treatment was provided earlier in the course of alcoholism (Cooper, 1913, p. 97). But amidst the rising stigma of alcoholism and the drives for county, state and then federal Prohibition, professional advocacy for treatment and recovery waned and the public voices of recovering people fell silent.

A psychotherapy clinic established at the Emmanuel Church in Boston in 1906 marked a pocket of continued hope for recovery from alcoholism. The clinic, which integrated medicine, religion, and psychology in the treatment of alcoholism, trained lay therapists who had been successfully treated for alcoholism at the clinic. Courtenay Baylor, the first of the Boston lay therapists, described this resolution of alcoholism in terms of "recovery" and "reconstruction"--the latter referring to fundamental changes that had to occur in the alcoholic's personality (Baylor, 1919, p. 38). Richard Peabody, the most famous of the lay therapists, later abandoned the concept of recovery, embracing instead a demedicalized view of the source and solution to alcoholism. Peabody saw alcoholism not as a disease of the body but as a "disease of immaturity" that required the alcoholic (who Peabody characterized as a "spoiled child"), not to recover, but to grow up via a reconstruction of personal character. When this moral and psychological reconstruction had occurred, the alcoholic was viewed not in a state of continuing recovery but as a person who had "rid himself of his habit once and for all"—"an ex-alcoholic" (Peabody, 1933, pp. 170-171,187). The Emmanuel Clinic was joined by a new generation of private hospitals and sanatoria that boasted of their abilities to treat alcoholism. For a brief time, the concept of *cure* again competed with the concept of *recovery*.

The founding of Alcoholics Anonymous (AA) in 1935 marked the re-emergence of *recovery* as a word and concept centrally linked to the resolution of alcoholism. The first (1939) edition of AA's basic text contained more references to *recovery* than any previous text, using the term *recovery* in the book's subtitle (*The Story of How More Than One Hundred Men Have Recovered from Alcoholism*) and proclaiming its purpose to describe "PRECISELY HOW WE HAVE RECOVERED" (caps in original text). Various forms of the word *recovery* appear more than 70 times in the first edition of AA's "Big Book" (Alcoholics Anonymous, 1939).

AA portrayed the resolution of alcoholism not as a decision or an event but an enduring process. It is with AA that we see the movement of *recovery* from a peripheral to a central, organizing construct. Prior to AA, the word *recovery* tended to imply the extended convalescence often required to reverse the physical ravages of alcoholism. It is in AA that we find the term used as the central concept depicting the ongoing cognitive, emotional, behavioral and spiritual reconstruction of the sobered alcoholic. Also significant was AA's shift in emphasis from recovery initiation (how to stop drinking) to recovery maintenance (how to not start drinking) and from chemical sobriety to "emotional sobriety" (Wilson, 1945). Positive coverage of AA by the American press in the mid-twentieth century stirred a resurgence of faith in the prospects that at least some alcoholics could permanently stop drinking. AA declared in the first edition of its basic text: "We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition" (AA, 1939, pp 104-105). The focus had shifted again from cure to recovery as a time-extended and multi-dimensional process.

Recovery, Treatment, and Backlash

Alcoholics Anonymous was part of a larger "modern alcoholism movement" that between 1935 and 1970 redefined America's conception of alcoholism and the alcoholic (Johnson, 1973; Roizen, 1991). The centerpiece of the modern alcoholism movement was a set of "kinetic ideas" that focused on the nature of alcoholism ("is a disease") and the alcoholic ("can be helped" and "is worthy of help") (Anderson, 1942; Mann, 1944). Through the efforts of the National Committee for Education on Alcoholism (the precursor to today's National Council on Alcoholism and Drug Dependence), the federal, state and local investment in alcoholism education and treatment expanded with a fully developed alcoholism field emerging in the 1970s. Public support for alcoholism treatment rose as Americans came to see alcoholism in medical rather than moral terms and as the popular image of the alcoholic shifted from that of the "Skid Row" wino to that of a family member, friend, neighbor or co-worker. Recovery also became more visible as many prominent Americans publicly declared their recovery from alcoholism in the late 1970s.

The eventual fruits of the modern alcoholism movement included a multi-billion dollar treatment industry; a broadened conceptual and institutional scope from alcoholism to chemical dependency, substance abuse, and addiction; the extension of the latter into the realm of "process addictions" (excessive and harmful relationships with people, work, money, gambling); and a shift in focus from the nature of AOD problems to the availability of effective interventions ("Treatment Works"). All were embraced within an amorphous, highly commercialized "recovery movement" that became something of a cultural phenomenon in the late 1980s and 1990s (White, 1998), with one social commentator referring to it as "recovery fever" (Blau, 1991). This phenomenon was marked by an explosive growth of Alcoholics Anonymous, the adaptation of AA to virtually every human problem, a recovery publishing boon, and an unending parade of celebrities entering and returning from "rehab."

The brief super-success of the recovery movement was followed in the 1990s by a backlash to this movement. The backlash took many forms, including attacks on the medicalized concept of addiction (Davies, 1997; Schaler, 2000), criticisms of the conceptualization of addiction as a disease (Fingarette, 1989; Peele, 1989); and challenges to the related concept of co-dependency (Kaminer, 1992; Katz and Liu, 1991). There were also sustained attacks on

addiction treatment (Peele and Brodsky, 1991) and on Alcoholics Anonymous and other Twelve Step programs (Bufe, 1991; Ragge, 1998; Peele and Bufe, 2000). There were financial backlashes against the treatment industry in the form of an aggressive system of managed care that led to the downsizing or closure of many hospital-based and private addiction treatment programs. These ideological and financial backlashes unfolded within the larger restigmatization, demedicalization and recriminalization of AOD problems during the 1980s and 1990s (White, 2000).

A Recovery Renaissance

In the wake of ideological and financial backlashes against the ill-defined and highly commercialized "recovery movement" (Kurtz, 1995), there is an emerging recovery renaissance within the alcohol and other drug problems arena.

In the sphere of recovery mutual aid, there are increasing varieties of Twelve Step experience (Kurtz and White, 2003), increasing numbers of adjuncts and alternatives to Twelve Step programs (Humphreys, 2004; White, 2004b), and a growing celebration of the diversity of American communities of recovery (White, 2000, 2002).

At national policy levels, this focused attention on recovery is evident in:

- President Bush's Access to Recovery Initiative which expands funding for recovery support services, broadens the range of agencies who can provide such services, and increases consumer choice in selecting providers of recovery support services (http://www.whitehousedrugpolicy.gov/treat/initiative.html).
- the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse's growing interest in the biological foundations of recovery, patterns and styles of long-term recovery, and development of new, post-detoxification, pharmacological aids to recovery.
- the Center for Substance Abuse Treatment's Recovery Community Support Program (http://www.treatment.org/Topics/archive/rcsp.htm) which has sought to involve recovering people and their families and allies in the enhancement of treatment and recovery support services, and Recovery Month activities which have promoted recovery-themed public education and recovery celebratory events (http://www.recoverymonth.gov/2002/links.htm).
- private foundation support for recovery-focused treatment system enhancements, e.g., Robert Wood Johnson's $9.5 million Paths to Recovery Initiative to enhance addiction treatment access and retention (http://www.pathstorecovery.org/)

There are also national efforts to survey the "recovery community" (Road to Recovery, 1998) and mobilize recovering people and their families into a "new recovery advocacy movement" (White, 2000). This movement is visible at a national level through the Faces and Voices of Recovery Campaign (www.facesandvoicesofrecovery.org) and is visible at state and local levels through the growing network of recovery advocacy organizations (e.g., www.ccar.org), a vibrant "wellbriety movement" in Indian Country (Coyhis, 1999; see www.whitebison.org), and the growth of faith-based recovery ministries, especially in communities of color (Sanders, 2002). Collectively these groups are pushing for recovery representation at AOD-related policy tables, recovery-focused community needs assessment processes, and the development of a full continua of local treatment and recovery support services (White, 2000).

Within the treatment arena, there is also a renewed recovery focus. There are calls to get treatment reconnected to the larger and more enduring process of recovery and to shift the focus of treatment from initiating recovery in the institutional environment to anchoring recovery within

the client's natural environment (White, 2002). There are calls to shift addiction treatment from an acute model of care (assess, admit, treat, discharge) to a model of long-term recovery management (RM) (White, Boyle, and Loveland, 2002; Edwards, Davis, and Savva, 2003; Moore and Budney, 2003). The (RM) model parallels approaches used in the treatment of other health disorders characterized by chronicity, course variability, and functional fluidity (McLellan, Lewis, O'Brien and Kleber, 2000; Dennis, Scott and Funk, 2003). There are also increased experiments with "peer-oriented recovery support services", recovery-focused service roles (recovery coaches/mentors/guides), and expanded recovery support structures (self-directed recovery homes) (Jason, et al, 2001).

In the arena of clinical research, there are researchers (e.g., Keith Humphreys, Alexandre Laudet) specializing in the study of recovery support groups, as well as calls for a recovery research agenda (White, 2000; Edwards, Davis, and Savva, 2003), increased meetings between researchers and recovery advocates, and significant new studies of post-treatment monitoring and recovery support services (Godley, Godley, Dennis, Funk & Passetti, 2002; Dennis, Scott and Funk, 2003).

A New Recovery Paradigm

This emergence of the recovery concept as a governing image for the field could be simply a passing fad or it could mark a major shift in the central organizing constructs that have shaped American responses to AOD problems. I have argued (White, 2004a) that this renaissance of interest in recovery is the latter. The pathology paradigm has focused on the nature of AOD problems and the nature of individual vulnerability to such problems. It has been based on the assumption that discovering the sources of AOD problems will provide keys to their resolution. Work within this paradigm has deeply enriched our understanding of addiction and has led to many refinements in the treatment of substance use disorders. The intervention paradigm has focused on methods and strategies of resolving AOD problems. This paradigm has been based on the assumption that the evaluation of active responses to AOD problems (whether at social policy levels or through individual-focused early intervention and treatment programs) will result in evidence-based solutions to these problems. The cumulative work within this paradigm has revealed both the benefits and limitations of addiction treatment as it is currently delivered in the United States. Recovery advocates and their professional allies within the treatment and research arenas are calling upon America and the addictions field to move beyond it central focus on AOD problems and their treatment to a more fully developed recovery paradigm. The assumption is that enduring solutions already exist to AOD problems in the lives of hundreds of thousands of individuals and families and in many communities and that a greater understanding of these individuals, families and communities will reveal more global solutions to AOD problem.

Advocates of the emerging recovery paradigm are calling upon treatment agencies and personnel to become more knowledgeable of, and involved within, local communities of recovery. They are pushing treatment programs to shift their focus from acute interventions to models of long-term recovery support services. Recovery advocates are calling for an intensification of pre-treatment recovery support services that strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, determine whether the individual/family can initiate and sustain recovery without formal, professionally-directed treatment services, or link the individual/family to the most appropriate treatment services. This recovery paradigm also suggests an intensification of in-treatment recovery support services to enhance treatment retention and enhance transfer of learning from institutional to natural environments. It is altering the nature and duration of the traditional service relationship. And it is shifting the focus of treatment from acute stabilization to post-treatment recovery management, e.g., post-stabilization monitoring (recovery check-ups), stage-

appropriate recovery education, recovery coaching, active linkage to communities of recovery, recovery community resource development, and early re-intervention. Creating recovery-oriented systems of care will require a reconceptualization of the continuum of care, changes in the selection and training of care providers and a reformulation of systems of service reimbursement. Some states (e.g., Connecticut and Arizona) have formally begun this process.

The concept of recovery as a governing image has had a long birth and a stormy adolescence but is poised to emerge as the central organizing construct within the addictions field. That emergence represents not so much an alternative to the pathology and treatment paradigms as a developmental extension of these earlier paradigms. That said, the recovery paradigm could dramatically alter the future of addiction treatment and broader responses to AOD problems in America.

Acknowledgement: Support for this article was provided by grants from the National Institute on Drug Abuse (Grant R01 DA15523 and Grant R03 DA13432) and the Illinois Department of Human Services (Office of Alcoholism and Substance Abuse Services) via the Behavioral Health Recovery Management project. The opinions expressed here are those of the author and do not reflect the opinions or policies of these agencies. The author would like to express appreciation to Mike Boyle, Mike Dennis and Chris Scott for their helpful comments on an early draft of this article.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2005). History Corner: The Jacoby Club and AA. *Recover Magazine*, 5(3), 28. Posted at **www.williamwhitepapers.com**

History Corner
The Jacoby Club and AA

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There is a rich history of persons suffering from alcoholism coming together to organize recovery mutual aid societies. In America, these societies date from eighteenth century Native American recovery "circles," which were followed in the nineteenth century by the Washingtonians, recovery-focused fraternal temperance societies, the ribbon reform clubs, the Dashaways and such treatment-linked support groups as the Ollapod Club, the Keeley Leagues and the Godwin Association. Most of these groups eventually collapsed, but there were a few groups (the United Order of Ex-Boozers and the Jacoby Club) that bridged these early efforts and the rise of Alcoholics Anonymous in the 1930s.

A recent book by Richard Dubiel, *The Road to Fellowship*, explores the influence of the Jacoby Club on the development of Alcoholics Anonymous. The Jacoby Club grew out of the Emmanuel Movement—an attempt to blend religion, medicine and psychology in the treatment of nervous disorders. Rooted within the Emmanuel Episcopal Church in Boston, this movement quickly developed a specialty in the treatment of alcoholism using recovering lay psychotherapists. In 1909, Ernest Jacoby founded the Jacoby Club as a meeting place for Boston citizens recovering from alcoholism. The Club grew rapidly to more than five hundred members under the slogan "A Club for Men to Help Themselves by Helping Others."

The Jacoby Club had several features that were later replicated in AA, including their emphasis on sober leisure and fellowship, an aversion to dogma and special support of new members (taking responsibility for a "special brother"). Publications about the Jacoby Club such as *The Lonesome Man* and *The City of Comrades* and annual reports with such titles as Men Who Have Won were filled with tales of "regeneration."

During the 1920s and 1930s, the Jacoby Club experienced internal conflict related to its primary mission, with some of its leaders wanting to continue the focus on service to the alcoholic while others wanted the Club to focus on the needs of older men in the community. As AA was going through

its early birth and development in Boston, there was a period of co-existence between the Jacoby Club and AA. Paddy K. used the Jacoby Club in his struggles to gain sobriety until he and Burt C. started the first AA meeting in Boston. As AA grew in Boston, the fortunes of the Jacoby Club declined. By the early 1940s, the Club was financially struggling, and Boston AA had taken over much of the Jacoby Club's service work with alcoholics.

The Jacoby Club continued its marginal existence serving older men until the Club's final demise in the late 1980s. In an interesting twist of historical continuity, Boston AA met for a time in the facilities of the waning Jacoby Club, absorbing the legacy and lessons of the Jacoby Club into the growing body of experience that shaped the character of AA. Those interested in that influence will want to read *The Road to Fellowship*.



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Citation: White, W. (2005). The voice of history: The evolution of recovery celebrations. Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery, Spring, p. 6. Posted at **www.williamwhitepapers.com**

The Voice of History
The Evolution of Recovery Celebrations

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Private and public celebrations of addiction recovery have evolved for more than two centuries. The roots of recovery mutual aid society meetings and recovery celebration events are closely intertwined and date to the Native American "recovery circles" of the mid-1700s. These celebrations continued with the public "experience sharing" meetings of the Washingtonian Temperance Society in the 1840s, the marches of the recovery-oriented fraternal temperance societies and reform clubs of the mid-1800s, the Keeley League marches and newspaper columns of the 1890s, and the Boozer Brigade marches through the streets of America's Skid Rows in the early 1900s. The closed celebration of recovery birthdays returned with new, mid-twentieth century recovery societies (AA, NA and Alcoholics Victorious), but these powerful stories of recovery rarely penetrated public consciousness until Marty Mann organized the National Committee for Education on Alcoholism in 1944.

NCEA spurred many celebrities to go public about their recovery, but these were isolated events until more than 52 prominent Americans stepped forward as part of NCA's Operation Understanding (1958) to publicly disclose their sustained recovery from alcoholism. While "going public" became something of a phenomenon among recovering celebrities in the 1970s and 1980s (famed actresses Lillian Roth and Mercedes McCambridge broke the ice of such disclosure much earlier), it wasn't until the late 1990s that recovery celebration events (e.g., marches, concerts, neighborhood clean-ups) as we know them today began. For more than two centuries, recovery celebration events have served as a ritual of mutual support and recommitment to recovery, a means of reaching out to the still-suffering addict, and an instrument of public education and public policy advocacy.

History often proceeds in small steps. There could have been no civil rights

marchers in Washington in 1963 if there had not first been those who walked in the 1955-1956 Montgomery bus boycott. There would have been no Martin Luther King, Jr. without a Rosa Parks. On the day a million years of recovery stand together in the nation's capital, we will honor the early recovery walks in states like Connecticut. We will honor the Hoop Journeys, the SoberJams and SoberFests. We will honor the power of a video called "The Healing Power of Recovery" and the humble brilliance of the "Recovery is everywhere" campaign. And we will honor the work of an organization called the Faces and Voices of Recovery. Recovering people have celebrated together for a long time, but compared to what is coming, the celebrating has just begun.



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Citation: White, W. (2005). The eight secrets of A.A.'s survival. *Recover Magazine*, 5(4), 28-29. Posted at **www.williamwhitepapers.com**

HISTORY CORNER
The Eight Secrets of A.A.'s Survival

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Alcoholics Anonymous, due to its membership size, worldwide dispersion, historical longevity and adaptation to other problems, has established itself as the standard by which all other recovery mutual aid societies are measured. Past History Corner columns have referenced such pre-AA recovery support groups as the Native American recovery circles, Washingtonians, Ribbon Reform Clubs, Keeley Leagues, Drunkard's Club and, one of my personal favorites, the United Order of Ex-Boozers. This column will answer the question: Why did AA survive and thrive when most of the pre-AA recovery societies failed to outlive their founding generation?

A.A.'s Close Call

In the early 1940s, A.A. came close to sharing the fate of its predecessors. A.A. was undergoing it first period of explosive growth and the growing pains were widely evident. At least one group drank beer at their meetings, and members of a San Francisco A.A. group, upset with the lack of communication from A.A.'s central office in New York, threatened to establish an alternative society called Dipsomaniacs Incognito. Conflict abounded over proposals for A.A. hospitals and paid missionaries, the operation of A.A. clubhouses, the founder's use of A.A.'s name in their involvement in outside organizations, and questions regarding the inclusion of women, gay men and African Americans. (See Wally P.'s (1995) *But, For the Grace of God...: How Intergroups & Central Offices Carried the Message of Alcoholics Anonymous in the 1940s*. Wheeling, WV: The Bishop of Books). A.A. could have self-destructed in the early 1940s. That it didn't is attributable to unique factors that distinguish A.A. from its predecessors.

A.A.'s Eight Protective Factors

As an addiction and recovery historian, I am often asked why A.A. escaped the fate of its predecessors. There is no evidence that early A.A. leaders were aware of earlier recovery societies before a July 1945 A.A. Grapevine article brought the experience of the Washingtonians into A.A.

consciousness. Discovery of the Washingtonians at a time AA was experiencing its own internal struggles played a significant role in A.A.'s future. Within a year of learning of the rapid growth and sudden demise of the Washingtonians, A.A. co-founder Bill Wilson formulated the Twelve Traditions that came to govern the group life of A.A. Listed below are the eight factors, including the traditions, that I most frequently cite as the secrets of A.A.'s survival.

Program Codification. A.A. was the first recovery society to refine and codify its program before it experienced explosive growth. The publication of A.A.'s basic text in 1939 minimized the future corruption of its program during periods of explosive growth.

Program Content. A.A. shifted the historical emphasis from sobriety initiation (how to stop drinking) to recovery maintenance (how to not start drinking). It broke from its predecessors by defining sobriety as something qualitatively different than not drinking, e.g., a new philosophy of living, a reconstruction of one's identity and character, and a reformulation of one's interpersonal relationships.

Organizational Autonomy and Singleness of Purpose. A.A. refused to tie its fate to any other organization. It separated from the Oxford Group and refused to align itself with any other organization. These twin principles helped A.A. escape early episodes that could have altered A.A.'s identity and mission, e.g., Bill's offer of employment as a lay alcoholism therapist and the offer to bring A.A. under the financial sponsorship of Towns Hospital.

De-decentralization of Leadership. A.A. avoided linking itself to a single charismatic leader. It pledging itself to a system of rotating lay leaders, a minimalist approach to organizational structure and governance by a Higher Power expressed within a group conscience. By eliminating permanent leadership positions and pledging itself to corporate poverty, A.A. eliminated the booty over which earlier groups had fought.

Cell Structure. Eschewing hierarchy, A.A. developed a highly de-centralized cell structure. The central essence of A.A. became members sharing their experience, strength and hope within small groups. A.A. transformed factors that had wounded earlier groups (conflict, and unmet needs) into catalysts of growth and cell division.

Alcoholic-to-Alcoholic Identification. A.A. was the first recovery mutual aid society that refused to compromise its closed (alcoholics only) meeting structure. The single but required membership criteria ("a desire to stop drinking") enhanced group cohesion and assured that no member could claim moral superiority over another.

Anonymity. A.A.'s principle of anonymity protected A.A. members from social stigma, protected A.A. from any public downfall of its members and evolved into a spiritual exercise in humility.

Duration of Participation. By creating an expectation that members would continue to participate long after stable sobriety had been achieved, A.A. assured organizational continuity and assured that the hand of A.A. would remain extended to the still suffering alcoholic.

Creating a sustainable alcoholic mutual aid society takes more than a workable framework of personal recovery. A.A., through its Twelve Traditions, found ways to manage those things that had destroyed its predecessors: conflicts over purpose, position, property, politics, personalities, and, of course, money.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W., Scott, C., Dennis, M. & Boyle, M. (2005). It's time to stop kicking people out of addiction treatment. Counselor, 6(2), 12-25. Posted at **www.williamwhitepapers.com**

It's Time to Stop Kicking People Out of Addiction Treatment

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Interventions by professional helpers that are later recognized as ineffective or even harmful have a long and colorful history. Some of the most widely practiced of such interventions have left later generations pondering, "What on earth were they thinking?" Lectures on the history of addiction treatment stir feelings of enlightened condescension amidst tales of treating morphine addiction with cocaine and other such idiocies, but occasionally a conference attendee asks the tough question: "How will the current era of addiction treatment be judged in the future?" And, of course, that is the rub, because it is so difficult to clearly see our own professional miscues and mistakes without the benefit of historical hindsight. This essay explores one practice—administratively discharging clients from addiction treatment—that we suspect will be judged harshly by historians of the not so distant future.

Administrative Discharge: Definition and Criteria

Administrative discharge (AD)—also referred to as "disciplinary discharge," "discharge for cause," or "discharge upon staff request"—is the adversarial termination of services due to a client's failure to comply with program rules and expectations. The reasons for AD vary by modality but generally include:

- Failing to participate in service activities, e.g., missing counseling sessions
- Threatening, or appearing to threaten, the physical or psychological safety of others
- Breaking rules regarding relationship boundaries, e.g., having phone or face-to-face contact with family members or friends during a "blackout" period, verbal abuse (profanity, racial slurs), or "fraternization" (sexual or other inappropriate activity with another client)
- Refusing to live within rules established for communal living (e.g., hygiene, assigned chores, disruptiveness, quiet

hours, and punctuality for treatment activities)
- Failing to pay service fees
- Possessing contraband in the treatment facility (e.g., illicit drugs, cigarettes, prohibited food items)
- Using alcohol or unprescribed drugs, or
- Failing to secure medication for a psychiatric condition.

The AD status is distinct from successful treatment completion (sometimes referred to as "planned discharge" or "graduation"), client termination of service participation against staff advice (also referred to as "against medical advice," "absent without leave" or "drop-outs," or referrals to another treatment resource (also referred to as "transfers").

Administrative Discharge Patterns

A review of the addiction treatment literature reveals a number of key findings related to current administrative discharge practices.

Definitional Problems Discharge categories and their definitions differ across programs, but there is evidence that discharge rates by type of discharge vary across community-based and prison-based treatment programs (Pelissier, Camp & Motivans, 2003) and vary from therapist to therapist within the same treatment program (Najavits & Weiss, 1994).

Discharge Status and Clinical Outcomes In adult populations, addiction treatment retention and completion are predictive of positive outcomes, and failure to complete treatment (including those administratively discharged) is predictive of worse outcomes (Price, 1997; Grella, Hser, Joshi, & Anglin, 1999; Wallace & Weeks, 2004). The role of discharge status on adolescent treatment outcomes is less clear, with one study noting superior outcomes for successful completers (Winters, Stinchfield, Opland, Willer & Latimer, 2000), and one study noting no significant differences between treatment completers and non-completers (Godley, Godley, Funk, Dennis, & Loveland, 2001).

Administrative Discharge Profiles Adult and adolescent non-completers are more likely to have clinical profiles marked by younger age, greater problem severity (although some studies report a positive link between severity and retention) psychiatric impairment (i.e., depression, conduct disorder, antisocial personality disorder, schizophrenia), history of perpetration of violence, less motivation for recovery, and less recovery supports in their family and social network (Godley, et al, 2001; Hser, Maglione, Joshi, & Chao, 1998; DeLeon & Jainchill, 1986; Agosti, Nunes & Ocepeck-Welikson, 1996; DeLeon, Melnick, Kressel, & Wexler, 2000; Pelissier, Camp & Motivans, 2003).

Administrative Discharge Prevalence and Level of Care Patterns At the present time, 18% (288,000 thousand) of the 1.6 million people admitted to publicly funded addiction treatment in the United States are administratively discharged (compared to 49% who complete treatment, 24% who leave against staff advice; and 9% who are transferred) (Substance Abuse and Mental Health Services Administration, 2002). Rates of AD are not uniform across levels of care. The highest to lowest rates of AD are found in methadone maintenance (30.7%), long-term residential (24.8%), outpatient (23.7%), intensive outpatient (19.8%), detoxification (9.4%), short-term residential (9%), and inpatient hospital treatment (4.6%) (SAMHSA, 2002).

Common Objectives for the Use of Administrative Discharges

In reviewing the literature and interviewing colleagues around the country about AD practices, we found five primary objectives that treatment professionals hope to achieve through the use of administrative discharge:

Objective #1: to protect the integrity of the treatment milieu. Administrative discharges are used to prevent and respond to disruptive behaviors that negatively impact the treatment environment. In this

view, individuals who are acting out are sacrificed for the greater good of other clients. Many readers would concur that therapeutic milieu is a crucial but fragile dimension of addiction treatment that can be compromised or lost. The AD stands as the ultimate instrument for preserving that milieu, even if applied in an inconsistent manner.

*Objective #2: to assure the best utilization of limited treatment resource. A*dministrative discharges are used to ration addiction treatment services to those who the treatment provider believes can most benefit from it. The AD practice assumes that programs have limited resources and clients who act out are wasting resources that more deserving others could be using. This objective is also met in some programs by discharging clients who cannot pay service fees on the grounds that the long-term financial integrity of the service organization takes precedence over the immediate needs of the non-paying client.

Objective #3: to protect the reputation of the treatment program. Administrative discharges are used to terminate services for clients who continue to use substances or exhibit other disruptive behaviors within the context of treatment. The assumption underlying such extrusion is that allowing clients to continue treatment while using would lead to a loss of community respect and support for the program. Rumors circulating within the using community regarding toleration of substance use during treatment could also damage the reputation of the program in the eyes of its most important constituents, including more compliant clients.

Objective #4: to prevent the treatment organization and its staff from enabling clients. Programs that use AD to achieve this goal assume that anything short of severing the service relationship with the AOD-using client would, by protecting the client from the consequences of his or her actions, constitute a form of professional enabling. In this view, there is therapeutic harm for continuing to treat the AOD-using client and therapeutic benefit (a motivational "wake-up call") resulting from treatment expulsion. Clients returning to treatment following AD who contritely confess that they weren't ready for treatment and that they needed a dose of reality add anecdotal support for this argument.

Objective #5: to fulfill the ethical obligation of terminating and (at least nominally) referring clients who fail to respond to program services The assumption guiding this objective stems from the need to protect clients from continuing exposure to treatments that are ineffective or potentially harmful due to the ideological biases or financial interests of the service provider (White & Popovits, 2001). Tempering this argument for AD is another ethical mandate: to not clinically abandon clients to whom one has pledged loyalty and availability.

These five objectives provide the primary rationalization underlying the majority of administrative discharges. These objectives make the act of administratively discharging the non-compliant client seem common sense, necessary and even noble. However, no program of qualitative or empirical research has been conducted to assess the validity of these objectives.

The Case Against Administrative Discharges

As noted, little research has been conducted to test the assumptions upon which current AD arguments rest, but numerous treatment agencies around the country are beginning to re-evaluate their AD practices. There are seven emerging arguments for stopping or significantly reducing the scope of client behaviors that can result in AD from addiction treatment and for developing programmatic responses that better benefit the client.

Argument #1. Administratively discharging clients from addiction treatment for AOD use is illogical and unprecedented in the health care system. A client is admitted to addiction treatment on the grounds that he or she has a chronic condition, the essence of which is the inability to abstain from or willfully limit their intake of psychoactive drugs in spite of

escalating problems related to such use. Significantly, the just-admitted client is told that AOD use is a violation of program rules and grounds for his or her termination from treatment. The client then consumes alcohol or other drugs in spite of the promised consequence—confirming the grounds upon which their diagnosis was made and their need for professional assistance. As a result of manifesting the primary symptom of the disorder for which the client was admitted to treatment, he or she is expelled from treatment.

We know of no other major health problem for which one is admitted for treatment and then thrown out for becoming symptomatic in the service setting. For other chronic health care problems, symptom manifestation serves as a confirmation of diagnosis or feedback that alternative methods of treatment and alternative approaches to patient education and motivation are needed. In marked contrast, symptom manifestation in the addictions field is grounds for expulsion from service.

Administratively discharging clients from treatment for alcohol or other drug (AOD) use is hypocritical and contradicts the very messages communicated by treatment center personnel to the larger community. The messages outward are that:

- The client is not in control of their alcohol and drug intake or its consequences
- The client needs professional treatment to reacquire such control
- Reacquisition of control over AOD use/nonuse decisions takes time and may be preceded by one or more episodes of relapse, and
- Long-term recovery is best supported by patience and support rather than punishment and abandonment.

Current administrative discharge practices in addiction treatment contradict these messages. We would hope that the days are numbered in which the addictions field can argue that addiction is a primary health care problem while its clinicians continue to treat the primary symptoms of addiction as bad behavior subject to "disciplinary discharge."

Expelling a client from addiction treatment for AOD use—a process that often involves thrusting the client back into drug-saturated social environments without provision for alternate care—makes as little sense as suspending adolescents from high school as a punishment for truancy. The strategy should not be to destroy the last connecting tissue between the client and pro-recovery social networks, but to further disengage the client from the culture of addiction and to work through the physiological, emotional, behavioral and characterological obstacles to recovery initiation, engagement, and maintenance. People with AOD problems should be afforded the same continuity of service contact that those with other chronic health and behavioral health problems are afforded (White, Boyle, & Loveland, 2003).

Argument #2. Administratively discharging clients from treatment for AOD use reflects a fundamental misunderstanding of the role of volition in addiction and recovery. The very essence of addiction is a progressive deterioration of the will—the erosion of volitional power to not use alcohol or other drugs or to regulate or stop such use once it is initiated. Volitional control over AOD use decisions should be viewed as a desired outcome of addiction treatment, not a required ticket of admission to treatment. If an individual could consistently exert such control, he or she would, by definition, not need addiction treatment. For those addicted and those recovering from addiction, free will exists, not as a dichotomous state, but in degrees of lost and reacquired power to maintain congruence between intent and actions. Treatment and sustained recovery involve a progressive rehabilitation of the will. Accountability for AOD use decisions makes sense only to the extent one has re-acquired the power to consistently assert one's choice over such decisions.

Argument #3. Administrative discharge currently casts the role of the treatment agency as one of persecutor, and misjudges the meaning and consequence of AD on the client. The synergy of addiction-related pain and hope of a better life

constitutes the critical catalyst of recovery initiation. To function as a motivation for change, painful consequences must be personally meaningful and directly linked to one's AOD use. Extruding an AOD-using client from treatment as a strategy of motivation assumes that extrusion from treatment will be experienced as a personally painful loss and further self-confirmation of the severity of the client's AOD problem. This is often not the case. First, it is typically only the secondary losses following such extrusion that tend to have meaning for the AOD-using client, e.g., loss of job, revocation of probation, lost custody of children. Without such secondary losses, we suspect the AD experience has little meaning or therapeutic effect, and shifts the role of the treatment program in the eyes of the client from that of benefactor to another source of the client's problems. Moreover, such losses create further despair and depression for the AD client, further promoting a return to AOD use.

Argument #4. Administratively discharging clients from treatment for rule violations is often the endgame in a process of escalating negative countertransference. Countertransference is the "total emotional reaction of the therapist to the patient" —a reaction that involves the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991). The euphemisms for the AD practice—"throwing" or "kicking" someone out of treatment—would suggest the act involves a discharge of anger from the staff toward the offending client. Such anger springs from a client's ability to stir feelings of disappointment, ineptitude, and frustration within service providers. The AD can constitute the abrupt end of a therapeutic relationship that has deteriorated into a contempt-laden struggle for power and face, e.g., "my way or the highway."

For recovering staff, countertransference can be further intensified by their personal recovery processes. John Wallace (1974) describes how early recovery is often characterized by a rigid preferred defense structure (PDS) (e.g., black/white thinking, denial, overcompensation, intellectualization) that therapeutically distances the individual from their past. With recovery stability, time and maturity, this early PDS softens or is abandoned completely. Service workers for whom these defense structures remain brittle may need to respond to the lapsing and relapsing client with particular harshness to distance themselves from their own vulnerability for relapse. Recovering workers may also perpetuate the act of AD as a process of intergenerational hazing, replicating rituals of expulsion that were common during their own treatment experiences. Staff with histories of unresolved addictions in their family and social histories may be similarly plagued by countertransference problems with the lapsing/relapsing client.

While AD can involve a specific toxic chemistry between a particular client and a particular service professional or service provider team, the pervasiveness of the AD suggests a much broader phenomenon may be at work. The AD may constitute a form of reverse "creaming"[1] through which the least attractive, least engaging, and most troublesome and time-consuming clients are skimmed from the caseloads of overworked and underpaid staff. Such processes might reflect a manifestation of the social stigma of addiction acted out inside the treatment milieu. The fact that African American and Hispanic clients are over-represented among those administratively discharged from addiction treatment (Illinois Office of Alcoholism and Substance Abuse, 2002) also suggests the need to examine the particular sources of such over-representation and the potential need for specialized and more culturally appropriate strategies to lower AD rates among people of color.

[1] "Creaming" is a euphemism for the practice of only admitting those clients who have the most financial resources and the best prognosis for recovery.

Argument #5. Administratively discharging clients often involves behaviors that are unrelated to, or have only a weak connection to, the prospects or processes of recovery or safety issues within the treatment milieu. One example is the use of AD as punishment for sexual activity between clients in addiction treatment. One is hard-pressed to find other arenas of health care in which sexual prohibitions are a condition of continued service access. Sexual activity between clients can constitute a legitimate clinical issue (behavior previously linked to addiction or that serves as an obstacle to recovery) and a milieu management issue (effect of behavior on other clients/staff), but this issue is best addressed clinically as part of the treatment process rather than as a disciplinary issue warranting expulsion from treatment. The exception to this principle would be when sexual behavior breaches the boundaries of physical safety or crosses criminal law (e.g., sexual harassment or sexual assault.)

The benefit/harm ratio of AD policies should also be examined related to other behaviors that have achieved an unwarranted level of importance and whose linkage to recovery initiation is weak or unclear, e.g., expelling clients for smoking, possessing contraband (e.g., tobacco, food/candy, caffeinated beverages, music or books), profanity, making phone calls, failing to go to or get out of bed on time, insubordination (refusing a staff order), missing meals, and oversleeping. Such issues should be addressed within the larger context of treatment and the helping relationship, not constitute grounds for service termination.

Argument #6. Administratively discharging clients from treatment projects casts the blame for treatment failure on the client and prevents treatment programs from evaluating and refining clinical practice. AD can flow from treatment technologies (or the problems in implementation fidelity) that fail to adequately engage the client or, in failing to meet the client's needs, leave the client to act out his or her historical pathology. For example, it is not uncommon to see a client with very high problem severity, complexity, and chronicity placed in a level of care of such brevity and low intensity that there is little likelihood of positive clinical outcomes. Alternatively, clients may be sent through the same treatment protocol again and again, even when the evidence suggests they likely need something different. When the predictable relapse occurs, the client is then extruded from treatment and subjected to environmental consequences on the grounds that he or she "had their chance." We would argue that such mismatches are not chances, but set-ups for failure, and that administratively discharging clients under such circumstances prevents programs from critically evaluating and improving their services.

Argument #7. Administratively discharging clients from a publicly funded addiction treatment program for failure to pay service fees constitutes clinical abandonment and is a breach of professional ethical principles and (potentially) legal and regulatory standards. It is normal business practice (and in some states a regulatory requirement) to assess clients entering publicly funded addiction treatment a co-pay portion of their total service fees based on each client's assets and income. It is also a normal business practice to make reasonable efforts to collect such fees. The question is whether inability to pay such fees due to either lack of financial resources or unwillingness to allocate resources toward this debt are grounds for termination of on-going treatment services. It may be, for example, that a person has legitimate and reasonable higher priorities for the limited funds they possess in early recovery, e.g., shelter, food, needs of their children. Reasonable payments plans should be negotiated as an alternative to service termination. It is our opinion that terminating publicly funded addiction treatment services for inability to pay is neither ethically nor clinically appropriate and that this category of AD should be now and forever abandoned. This position would not prevent organizations from pursuing collection of fees subsequent

to treatment through other means (e.g., payment plan, work programs).

Policy Strategies to Reduce Administrative Discharge

Lowering the rate of AD within the American system of addiction treatment will require changes at policy, programmatic, and service relationship levels. A good starting point for policy level changes would be a NIH/NIDA- or SAMHSA-sponsored consensus panel to explore standards for, and alternatives to, AD within addiction treatment programs. The goals of the consensus panel would be to make recommendations regarding consistent AD definitions and AD data collection and reporting procedures (to allow country-to-country, state-to-state and program-to-program comparison of variance in AD rates), and to recommend policies and clinical procedures that could lower AD rates. In fact, standards could be set for 'best practices' in this regard. The Network for the Improvement of Addiction Treatment, a joint effort of the Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation, has already started addressing these issues to achieve their goal of increasing retention in addiction treatment. Some state addiction authorities (e.g., Texas) are promulgating policies that prohibit the exclusion and extrusion of clients within particular program tracks (e.g., programs for co-occurring disorders) on such grounds as prior treatment failure or continued substance use. A similarly important policy step would be to prohibit publicly funded addiction treatment programs (via licensure standards and contractual requirements) from severing services on the basis of a client's inability or failure to pay service fees without making alternative and satisfactory arrangements.

The research infrastructure that supports addiction treatment needs to be encouraged and given incentives to pursue a research agenda related to AD practices, effects, and alternatives. There are critical influences on AD practices that need to be explored, including the effects of program modality/philosophy, staff background and experience, and client characteristics, as well as the potential influence of waiting lists on AD practices, (e.g., Does front-end service demand lower thresholds for deviance that generate back-end extrusion? Can successful interventions be developed for lowing the AD rate?).[2] As a field, we need to know the long-term effects of AD on addiction and recovery careers, e.g., do administrative discharges generate therapeutic, neutral, or iatrogenic effects on those discharged, and do these effects vary across demographic and clinical subpopulations? Research suggests that, for many clients, the period of time between their first treatment episode and achievement of their first year of sobriety can span an average of 3 to 4 treatment admissions over the course of 8 years (Dennis, Scott, Funk, & Foss, in press). If we shift from thinking about individual episodes of care to these longer treatment careers — then we must evaluate whether AD hastens the relapse process (accelerating the transition between lapse and full relapse), reduces the likelihood and speed of the client returning to treatment (given that it was a negative experience), and results in increased health, social and economic consequences for both the individual, the family, and society.

We also need to explore how service reimbursement systems influence the rate of AD in addiction treatment. Where service demand is high, there are no current incentives for client retention and completion, or disincentives for AD. There may, in fact, be incentives to process the largest numbers of individuals or service units with the minimum amount of staff resources by replacing the most difficult to treat clients with the easiest to treat. Ideally, there would be incentives for addiction treatment programs to engage, retain, and facilitate positive outcomes across episodes

[2] Feedback from key informants noted that such pressure increased as waiting lists grew longer and referral sources became more aggressive in their attempts to get their clients admitted to treatment.

of care/time with clients who present with the highest problem severity and the most chronic histories of relapse and re-admission.

Programmatic Alternatives to Administrative Discharge

There are several responses at the program design and service delivery levels that could potentially reduce AD rates. Pending scientific confirmation of the most effective strategies to lower these rates, the authors would recommend the following.

Recommendation #1. Create a culturally appropriate pre-treatment engagement and orientation process aimed at enhancing motivation for change (via recovery role modeling and motivational interviewing), heightening and yet moderating ambivalence (about continued use), identifying chronic self-defeating styles of interacting with professional helpers (learning how to be helped), resolving environmental obstacles to recovery, mobilizing recovery support resources within the family and kinship network, empowering the client/family to participate in the admission and level of care decisions, setting mutually agreeable goals with the client/family for each level of care, and supporting the client/family through any delay in service initiation. The purpose of such engagement efforts is to transition the client from the extrinsic (environmental) motivators that trigger entry to treatment to the intrinsic motivators that catalyze and sustain long-term recovery. This pre-treatment (recovery priming) level of care would also serve as a sanctuary within which clients who clinically deteriorate within other levels of care could be transferred for re-evaluation, stabilization and replacement in a suitable level of care.

Recommendation #2. Create a feedback loop between discharge processes and assessment and admission processes to determine the extent to which administrative discharges, clients leaving against staff advice, and transfers to other programs result from inadequate assessment, inappropriate admission, or level of care misplacement. Reducing failure to complete rates is likely contingent upon improving front-end assessment and placement decisions. Failure to consider alternatives to inpatient/residential care and forcing such high intensity levels of care when clients present legitimate needs to remain in their homes (e.g., caretaking responsibilities) often contributes to early treatment cessation. Developing more nuanced screening and assessment tools and more clinically flexible decision trees for admission/placement could potentially lower AD rates (Pelissier, Camp & Motivans, 2003).

Recommendation #3. Create alternatives to reduce the misuse of residential/inpatient addiction treatment. As community caretaking resources tighten under the influence of fiscal austerity, people can be referred to residential addiction treatment not because they need such services but because there are no resources for what they do need, e.g., housing, monitored sequestration from the community. Advocating, supporting and utilizing community alternatives to address these needs (e.g., housing alternatives, day reporting programs, electronically-monitored home confinement) can prevent residential treatment programs from becoming revolving doors for persons not seeking and who do not need this level of addiction treatment services.

Mismatches between client needs and placement decisions can also flow from systems of placement criteria that rely primarily or exclusively on problem severity. Problem severity criteria direct people to residential treatment who do not necessarily need such resources (because of offsetting intrapersonal and interpersonal resources) or who have broader needs that conflict with residential placement. Such mismatches can lead to acting out and consequently to AD. More individualized, creative and assertive approaches are likely to reduce the frustration and acting out that currently lead to AD.

Recommendation #4. Minimize "rules" and maximize processes of

engagement and motivational enhancement. Excessive rulemaking can shift the focus of the treatment milieu toward one of control and compliance rather than relationship building and recovery, and sets up many unnecessary and unproductive authority conflicts between clients and service providers. A practice of collecting and passing on the wisdom of former clients to current clients (the peer-based message "It has been our experience that…" rather than the authority-based "Thou shall not…") might prove more effective.

There is precedence for such flexibility. Early in its history, Alcoholics Anonymous abandoned its excessive membership rules designed to keep out and kick out those characterized in the late 1930s and 1940s as "beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women" (AA, 1952/1981, p. 140). AA replaced such misguided exclusiveness with the simplest of admission criteria ("a desire to stop drinking") and a welcoming message ("keep coming back") that keeps its doors open to the still struggling, still-drinking alcoholic. That model of simplicity and inclusiveness is worthy of emulation.

Recommendation #5. Continue to reassess all changes in clinical status as a matter of policy, rather than relegate assessment to an intake function. Such reassessment opens the opportunity for early re-intervention prior to the onset of AOD use by clients in treatment. Lapse and relapse prevention and their management ideally begin during rather than after treatment. Reassessing changes in status during treatment can reveal particular points of vulnerability in the early recovery process, including mismatches between service interventions and emerging stages of recovery that can spark a breakdown in the service relationship and the clinical deterioration that often follows. In fact, for clients with the most severe conditions, this process of continuity of contact and reassessment should span multiple episodes of care over years, as is the case with the treatment of other chronic conditions like cancer, diabetes, hypertension and depression (McLellan, Lewis, O'Brien, & Kleber, 2000)

Recommendation #6. Assign a patient advocate, primary counselor, and/or knowledge about a program ombudsman immediately upon admission and assure that one-on-one time occurs daily during the earliest period of treatment. The goals of such intense professional and peer-based recovery supports are to constantly re-engage, re-motivate, process negative emotion, celebrate incremental progress and resolve problems that can escalate into premature service termination. The most crucial key to increasing treatment completion rates is the power of *relationship*.

Recommendation #7. Assure adequate doses of medication and the availability of recovery support services within methadone maintenance treatment (MMT) and detoxification programs. Inadequate dosing and lack of psychosocial supports contribute to drug supplementation via unapproved AOD use, staff-client conflicts, and poor treatment retention rates in MMT (Capelhorn, McNeil, & Kleinbaum, 1993; National Consensus Development Panel, 1998). When MMT clients with high tissue tolerance encounter low dose clinic policies, the results are often withdrawal distress, self-medication with alcohol and illicit drugs, and punishment of the client (via administrative discharge) rather than identification of the clinic's failure to provide competent treatment. Though less documented, a related problem is inadequate dosages during detoxification. Even where drugs like buprenorphine are prescribed to help withdrawal, their use may be discouraged under the misguided assumption that withdrawal discomfort will help motivate the recovery process. What is more likely is the client leaving against staff advice, failing to transfer from detox to treatment, or becoming agitated and getting administratively discharged from treatment. Adequate dosing is the single most important contributor to MMT retention, but adequate dosing alone is insufficient to stop AOD use among clients deeply enmeshed in drug-using subcultures. Better counseling and recovery support services can, by

enhancing disengagement from such cultures and facilitating engagement in local communities of recovery and the larger civilian community, reduce behaviors that lead to administrative discharge (McLellan, Woody, Luborsky, & Goehl, 1988; McLellan, Arndt, Metzger, Woody, & O'Brien, 1993).

Recommendation #8. Establish clinical supervision and internal discharge review protocol as frameworks to identify and resolve negative countertransference, address client-staff conflict/grievances, process level of care transitions, structure the process of service termination, and debrief AD decisions. Reducing administrative discharges is contingent upon a sound clinical infrastructure—the centerpiece of which is consistent and competent clinical supervision—and the development of internal mechanisms of review of all recommendations for administrative discharges.

Recommendation #9. Provide continuity of contact in a primary recovery support relationship that potentially spans multiple levels of care and multiple developmental stages of recovery. Many clients entering addiction treatment have histories of victimization and abandonment that make them hypersensitive (and prone to act out during) changes in intimacy levels within important relationships in their lives. Replacing constant relationship transfers (e.g., from the intake specialist to the inpatient counselor to the outpatient counselor to the continuing care counselor) with a more primary and sustainable recovery support relationship reduces the propensity for clients to behaviorally act out their anxiety surrounding such losses and transitions. Experiments are currently under way to provide such continuity through the use of peer-based recovery coaches.

Recommendation #10. Evaluate lapses, relapses and other disruptive behaviors clinically prior to their evaluation administratively. An episode of AOD use or unremitting AOD use has different meanings for different clients. It is best to evaluate what the current pattern of AOD use means in terms of a particular client's addiction and recovery careers. In this view, AOD use during treatment is another source of clinical data that, taken with other data, calls for a re-evaluation and refinement in the service plan. Lapses and relapses should be evaluated based on: 1) whether they involve a primary or secondary drug (secondary drug use may indicate an attempt to stave off primary drug relapse in the face of increased craving, cue exposure, or emotional distress), 2) the timing of use (e.g., stage of addiction/recovery; change in level of care), 3) the physical, psychological and social context of use; 4) the intensity of use (e.g., risk to self and others), 5) the duration of use, and 6) the client's response to use (e.g., meanings and motivations). The goal is to transform near lapses and lapses/relapses from windows of vulnerability for re-addiction to windows of opportunity for recovery enrichment. The latter is achieved by eliciting from the experience new motivations, perspectives and skills that can stabilize and strengthen the long-term recovery process.

Recommendation #11. Use transfers between levels of care, service modalities or service settings instead of AD as the primary response to AOD use and other disruptive behaviors. We would be the first to acknowledge that a client's AOD use or other behavioral indicators of clinical deterioration could render the client inappropriate for a particular level of care or program at a particular point in time. If such a client's behavior becomes unmanageable, the next best approach is to consider transferring the client to an alternative treatment approach or service setting. Flexibility seems to be the key to retention. Where the professional recommendation is for methadone maintenance but the client wishes to try a short-term trial of buprenorphine, we suggest trying the client's way with an agreement to try alternatives if the first approach does not work.

Recommendation #12. Leave the door open for readmission following AD or transfer attempt from any level of care. At the point of termination from a level of care, define the conditions under which readmission will be possible and continue to monitor people who have been

administratively discharged via recovery checkups (by phone whenever possible), linkage to recovery mutual aid resources and re-engagement in treatment (see Dennis, Scott & Funk, 2003 for recovery checkup protocol). Monitoring the status of extruded or transferred clients creates connecting tissue between service episodes and has the potential to shorten addiction and treatment careers. We believe as a matter of policy that all clients should be provided access to referrals for continuing care regardless of discharge status. The goal for clients with the greatest problem severity and lowest recovery capital (intrapersonal and interpersonal resources) is to find service combinations and sequences that have amplified effects in moving the client through recovery priming and initiation to recovery maintenance. The service relationship goal is to build a relationship that is sustainable even in the face of a client disengaging from, or acting his or her way out of, treatment. The message to each client is: "we are unconditionally committed to your recovery and that commitment continues regardless of your discharge status" (J. Schwartz, Personal Communication).

Alternatives to Administrative Discharge for the Frontline Clinician

For the front line addiction counselor, we would suggest six strategies to lower AD rates.

Strategy #1. Find ways to rise above the paper and the procedures to personalize your services to clients. Spend time with your clients—with no paper and no treatment task agendas—to get to know each of them as individuals. Find ways to increase your one-on-one time with each client. The quality and frequency of positive contact may be more important than the time involved in any single contact. Continuity of kindness, respect, and regard go a long way in lowering the resistances that can arise within any helping relationship.

Strategy #2. Recognize each client's historical pattern of resisting change, including past self-defeating styles of relating to professional helpers. Anticipate that such styles will be replicated at some point within the current service relationship and explore with the client how to break such patterns to create a more positive treatment outcome (See White, 1996). It is important to realize that many clients are trapped in an immature stage of development in which they have fleeting moments of clarity one day, but then repeat the same mistakes the next.

Strategy #3. Hate the condition and love the person. When feeling anger, frustration and disappointment toward a particular client, separate the person from the disorder. Find and draw out the person masked by the disorder, and recognize that addiction can shroud the person in a most unlovable veneer. If anyone could get through this veneer, there would be no need for addiction counselors. Getting through the disorder to the person is the very essence of addiction counseling.

Strategy #4. Utilize peer or clinical supervision to process your feelings toward your most difficult clients and to brainstorm how to handle difficult problems. Seeking such support is not a sign of incompetence or lack of emotional fortitude. It is the very epitome of professionalism and an effective antidote to fatigue and burnout.

Strategy #5. Extend special effort to engage and counsel individuals with multiple prior episodes of treatment. At your worst moments, you must stem the propensity to see such clients as "retreads" or "losers." Remind yourself of these key points:

- Many people suffering severe and persistent addiction will require multiple episodes of treatment before stable recovery is achieved—yet over half do recover and this is one of the highest recovery rates of behavioral, psychiatric and many chronic health disorders.
- What I do as an addiction professional in this episode of care could shorten or lengthen my client's addiction career.
- There are developmental windows of opportunity that can open in all of our lives and forever change the trajectory of who we are at a most fundamental level.

- What I do or fail to do with this client at this moment could open or close this window of opportunity.
- I must find a way to seed the very essence of recovery within my relationship with this client.

Bill Wilson, co-founder of Alcoholics Anonymous, and Marty Mann, founder of the National Council on Alcoholism and Drug Dependence, were both treatment recidivists (ten prior treatments between them before finding sobriety). Their clinicians—Dr. William Silkworth and Dr. Harry Tiebout, respectively—through positive regard and perseverance found ways to tip the scales of their lives from continual re-addiction to relocation in the psychological and social worlds of recovery. Remind yourself that sitting among the recidivists you counsel could be the next Bill Wilson or Marty Mann, and that the ability to achieve or not achieve his or her personal and historical destiny may rest, in part, on the nature of what you bring to the service relationship.

Strategy #6. Respect the diversity of recovery pathways and styles. Each client has to find his or her own pathway to recovery. The good news is that there are many such pathways and styles of recovery initiation and maintenance. Our job as service professionals is not to program this pathway for each client, but to help each client use the building blocks of their own individual experience and those who have recovered before them to forge an approach to recovery that personally and culturally works. Recognize your own recovery pathway/style biases, educate yourself to alternative pathways and styles of recovery, and open yourself to the possibility that each client may find a pathway of recovery quite different than your own and quite different than any you have witnessed in the lives of your previous clients.

Summary

The addiction treatment field has a long history of administratively discharging clients for alcohol and other drug use and other prohibited behaviors. Such extrusion has been justified on clinical, ethical, and organizational grounds. It is argued here that this practice, as it has been extended to an ever-widening array of behaviors, is illogical, hypocritical, and counterproductive. Policy, programmatic, and clinical strategies are suggested as potential means of reducing AD Rates.

It is time that we as a field dramatically reduce the circumstances within which we expel clients from addiction treatment. It is time we asked ourselves: Would more than 200,000 clients be thrown out of addiction treatment each year if we really believed that addiction was a chronic disease from which recovery was not only possible, but a living reality in the lives of hundreds of thousands of individuals and families? Our clients are not at their best at the times they are on the verge of being thrown out of treatment, but we are quite often not at our best at such moments either. It is time we were.

Acknowledgement: Work on this paper was supported by grants from the National Institute on Drug Abuse (Grant R01 DA15523 and Grant R37 DA11323). The opinions expressed here are those of the authors and do not reflect the opinions or policies of any governmental agency. We would like to thank the following people for sharing with us AD practices in their areas or sharing their thoughts and comments on early drafts of this paper: Jim Balmer, Ben Bass, Brian Coon, Alexandre Laudet, Joe Powell, Bob Savage, and Jason Schwartz.

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www.williamwhitepapers.com

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Citation: White, W. & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, 6(4), 58-61.
Posted at www.williamwhitepapers.com

Styles of Secular Recovery

William L. White and Martin Nicolaus

The last essay in this column noted the growing diversity in religious, spiritual and secular frameworks of recovery and sketched the history of religious approaches to addiction recovery. This essay reviews the history and growing varieties of secular recovery and the implications of such diversity for the addictions professional.

A History of Secular Recovery

The history of non-religious, non-spiritual approaches to the resolution of alcohol and other drug problems begins with the Washingtonian Revival of the 1840s. The Washingtonians removed preachers and physicians from the temperance lectern in favor of men and women who, in the vernacular of the day, were "reformed" or were "reforming." The Washingtonians replaced religious admonitions not to drink with 1) public confession of one's addiction, 2) a signed pledge of abstinence, 3) visits to younger members, 4) economic assistance to new members, 5) experience sharing meetings, 6) outreach to the suffering drunkard, and 7) sober entertainment and fellowship. While many Washingtonians entered the life of their local churches, Washingtonian leaders were charged by their religious critics with committing the sin of humanism--placing their own will above the power of God. Recovery support societies that followed the Washingtonians took on a more religious orientation, but secular recovery groups continued in some of the mid-century moderation societies, ribbon reform clubs and support societies that grew out of early treatment institutions, e.g. the Ollapod Club and the Keeley Leagues.

The Jacoby Club, a recovery support society that grew out of the Boston Emmanuel Church's early twentieth century program of lay psychotherapy for alcoholism, later separated from the church and shifted to a more secular framework of recovery support. The lay alcoholism psychotherapists of this period shifted from a religious approach (e.g., the early work of Courtenay Baylor) to a strictly secular approach (e.g., the later work or Richard Peabody).

The near-exclusive dominance of Alcoholics Anonymous, Narcotics Anonymous and other Twelve-Step recovery societies in the mid-twentieth century was balanced in the last quarter of the twentieth century by a plethora of non-spiritual, non-religious recovery support programs. Such programs (and their founding dates)

included Women for Sobriety (WFS) (1975); Secular Sobriety Groups (later renamed Secular Organization for Sobriety—Save Our Selves (SOS) (1985); Rational Recovery (RR) (1986); Men for Sobriety (MFS) (1988); Moderation Management (MM) (1994); SMART Recovery (1994); and LifeRing Secular Recovery (LSR) (1999). Many of these groups were influenced by the work of Carl Rogers and Albert Ellis. The growth of religious and secular alternatives to Twelve Step programs has produced the largest continuum of recovery support structures that has ever existed in history.

LifeRing: Organizational and Membership Profile

One of the more recent secular recovery support societies is LifeRing Secular Recovery. To provide a more in-depth look at secular recovery, we provide a brief profile of the history and current status of LifeRing. LifeRing was officially founded in 1999, though many of its early members had been previously involved in Secular Organizations for Sobriety (SOS). Since 1999, LifeRing has provided mutual support through participation in face-to-face meetings (80 groups in 20 states and four countries) (69% of members), the LSR email list (43% of members), participation in online (www.unhooked.com) chat rooms (33% of members), Internet forum (bulletin board) (18% of members), LifeRing social events (14% of members), or attendance at a LifeRing Congress (16% of members). LifeRing members also consume a growing body of secular recovery literature.

A just-completed survey of LifeRing members provides a profile of those involved with secular recovery. Based on a survey of 401 members, LifeRing members are predominately middle-aged (average 48), White (81%), educated (81% with college experience and 46% with a bachelors or advanced degree), and close to gender-balanced (men, 58%; women, 42%). Members report diverse religious backgrounds (Protestant, 31%; Catholic, 25%; Jewish, 4%; other, 16 %; and none, 24%), although 82% report either no participation or minimal participation in the past year. Most LifeRing members report sustained exposure to alcohol, prescribed and illicit psychoactive drugs and 35% report concurrent recovery from a psychiatric disorder (primarily depression and anxiety).

LifeRing members participate in the organization to support their own recovery (84%) or to provide personal or professional support for the recovery of another. Most members began participation in LifeRing following referral by a counselor or friend in recovery or by discovering LifeRing on the Internet. Three-fourths of LifeRing members had prior contact with a Twelve Step program before their involvement in LifeRing.

Distinguishing Themes

The critical difference between religious/spiritual and secular programs of addiction recovery rests primarily on different views of the source through which addictive behavior is corrected. The former, via the concepts of religious surrender or AA's concept of powerlessness, posit that only external, transcendent resources (a Higher Power) can rescue the addict from his or her entrapment. Secular models, in contrast, acknowledge the power of addiction, but also posit an opposite power—an irrepressible resilience--within the self that seeks freedom from the drug and pushes the addicted person toward recovery and a meaningful life. Women for Sobriety affirms the recovering woman's strength of character and posits the source of recovery inside the self; Rational Recovery relies on the power of a rational brain to wage battle against the inner Beast; SMART Recovery extols the virtue of self-reliance, assertive problem solving and lifestyle balance; and LifeRing paints an addict self and a sober self struggling for dominance within the recovering person. The themes of most secular recovery groups are illustrated in LifeRing's "Three-S" philosophy: sobriety ("We do not drink or use, no matter what."), secularity (the inclusion of people of all faiths and no faith within a mutual support process that emphasizes achieving recovery through human rather than divine intervention), and

self-help (a focus on individual motivation and effort).

Religious, spiritual and secular addiction recovery support groups are similar in their practical tools for problem resolution, warm social fellowship, and emphasis on experience sharing. In spite of these similarities, secular groups are distinguished by lack of references to religious deities, less emphasis on self-labeling ("alcoholic" and "addict"), greater emphasis on personal empowerment, an openness to crosstalk (direct feedback and advice), the lack of formal sponsorship, and encouragement to complete a recovery process and move on to a full, meaningful life (rather than sustain meeting participation for life). Some of the secular groups (e.g., SMART Recovery) also use volunteer professional advisors (persons not in personal recovery) to facilitate and speak at meetings.

Implications for Counselors

So what are the implications of this growing diversity of styles of recovery for the addictions professional? Addiction counselors across the country are developing new understandings and changing their clinical practices based on this diversity. These new understandings include the following.

There are multiple pathways of long-term recovery. People are resolving alcohol and other drug problems of variable severity through **r**eligious, spiritual and secular approaches, and are doing so with and without formal recovery mutual aid involvement and with and without professional treatment (Humphreys, 2004; Dawson, et. al., 2005). Religious, spiritual and secular recovery support groups all contain a core of members who have achieved stable, long-term recovery.

Client choice enhances recovery motivation and recovery outcomes. The addition of a secular option introduces an element of choice into treatment planning that can generate powerful motivational benefits for some clients. Patient choice is today standard practice in medical treatment of heart disease, cancer, and other primary disease, and the value of choice is being increasingly confirmed in behavioral health research (Hester & Miller, 2003). The celebration of recovery pluralism and a philosophy of choice should be the core of comprehensive systems of care for substance use disorders.

Pathways of long-term recovery differ in their core ideas, sense-making metaphors, and their rituals and techniques of recovery initiation and maintenance. These differences are reflected in the growing variety or recovery mutual support societies. The implication of this understanding is that counselors need to provide a menu of ideas, metaphors, rituals and techniques that are as diverse as the client populations with whom they are working.

Acknowledging the legitimacy of secular recovery groups or referring individuals to such groups does not, per se, undermine a program's abstinence orientation. Although the major moderation group in the United States (Moderation Management) is secular in its orientation, most secular groups are strongly abstinence-oriented. The addition of an abstinence-based secular option within programs with a strong abstinence philosophy reinforces the abstinence message from two otherwise philosophically divergent positions.

The addition of a secular option does not automatically engender tension or friction between clients in treatment. Groups such as LifeRing have been operating side-by-side with 12-step groups on the same treatment premises for years without antagonism. Seeing the diversity of ways people are resolving alcohol and other drug problems tends to enhance client confidence in the prospects of recovery and engender tolerance toward these different pathways.

People seeking recovery may use religious, spiritual and secular frameworks exclusively, concurrently or sequentially. Individuals may learn to reinterpret a single framework over the span of recovery, may use simultaneous involvement in multiple recovery support societies to meet different recovery needs, or may use one framework to initiate

recovery and another framework to maintain and enrich recovery. Fifty-five percent of LifeRing members we surveyed report continued participation in Twelve Step groups. Of those participating in more than one recovery mutual support society, 44% consider LifeRing the most important for their recovery while 30% consider LifeRing and Twelve Step programs equally important to their recovery. Similar findings of concurrent involvement in AA and secular recovery groups have been reported for WFS (Kaskutas, 1992) and SOS (Connors, et. al., 1992). While the concepts used by religious, spiritual and secular recovery groups differ significantly, it seems that many recovering people have discovered how to selectively draw upon these concepts to support their long-term recoveries.

The recognition of multiple (including secular) pathways of recovery is changing clinical practice in a number of important ways. Embracing a "whatever works" philosophy, growing numbers of addiction counselors are:

- Educating themselves about secular alternatives to addiction recovery
- Meeting with the institutional or service committees of local secular recovery groups
- Exploring with each client which ideas, words, rituals and support structures will best serve to catalyze or anchor recovery
- Including secular recovery literature within client education materials
- Including secular groups as a referral option (leaving it to each client to decide which mutual support structure bests fits his or her needs)
- Expanding the language of counseling to reflect inclusiveness of religious, spiritual and secular pathways of recovery, and
- Inviting representatives of all local recovery support groups to speak to clients or host meetings within their treatment facility.

A day is rapidly approaching when addiction counselors will be knowledgeable about the whole spectrum of religious, spiritual and secular pathways of long-term recovery. Recovery from addiction is cause for celebration whether that recovery comes through a transcendence of self or an assertion of self.

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Citation: White, W. (2005). The Drunkard's Club. Recover Magazine, 5(2), 28. Posted at **www.williamwhitepapers.com**

HISTORY CORNER

The Drunkard's Club

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To many people, the history of alcoholic mutual aid societies begins in 1935 with the founding of Alcoholics Anonymous. A.A. history buffs are aware that there was another society, the Washingtonians, that existed almost a century before the meeting of Bill Wilson and Dr. Robert Smith. But few are aware of just how many pre-A.A. alcoholic mutual aid societies existed before 1935. There were early Native American recovery "circles" that date as early as 1750, numerous recovery-focused fraternal temperance societies, many branches of the ribbon reform clubs, the United Order of Ex-Boozers, and the many societies that were linked to 19th and early 20th century treatment institutions: The Ollapod Club, the Godwin Association, the Keeley Leagues, and the Jacoby Club, to name only a few. A.A.'s survival takes on added historical significance in light of the demise of all of these predecessors.

The fate of one of these pre-A.A. mutual aid societies is detailed in Charles Brace's 1872 book, *The Dangerous Classes of New York*. Brace tells the story of Orville "Awful" Gardner, a prize-fighter, known for his drunken binges and his brutality in and outside the ring. (He once bit off a man's nose.) Gardner experienced a profound religious conversion through which he became sober and experienced a call to help other "hard cases" like himself. Gardner opened a "Coffee and Reading Room" in a ward in New York City notorious for its drunkenness and vice. This small experiment evolved into what became known as "The Drunkard's Club." Brace describes:

The rooms are filled with reformed or reforming young men. The great difficulty with a man under vices is to make him believe that change for him is possible. The sight of Gardner always demonstrated this possibility. The place has become a kind of central point for all of those who have become more or less addicted to excessive drinking, and are desirous of escaping from the habit.

According to Brace, more than 700 men were sobered under the influence of the Club. The fate that befell that Drunkard's Club was not atypical of pre-A.A. mutual aid societies. Gardner's health began to fail from the "strain of his sins and his reform" and he was forced to retire to a quiet place in the country. Without his leadership, the Drunkard's Club collapsed.

In an interesting twist of historical continuity, it was this same "Awful" Gardner who inspired the religious conversion of another alcoholic, Jerry McAuley, while both were in Sing Sing Prison. McAuley went on to found the Water Street Mission, the first urban mission that catered its message and services to the late stage alcoholic.

Like the Phoenix rising from the ashes of its own pyre, new addiction recovery mutual aid societies followed the Drunkard's Club until the first society arrived with the right combination of recovery principles and organizational practices that allowed it to outlive its founding generation.



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Citation: White, W.L., Gasperin, D., Nystrom, J., Ambrose, C.T. & Esarey, C.N. (2005). The other side of burnout: Exemplary performance and health among probation officers. Perspectives: The Journal of the American Probation and Parole Association, 29(2), 26-31. Posted at **www.williamwhitepapers.com**

The Other Side of Burnout: An Ethnographic Study of Exemplary Performance and Health among Probation Officers Supervising High-Risk Offenders

William L. White, MA, David L. Gasperin, BA, Judi L. Nystrom, BA, Charles T. Ambrose, MA, and Carol N. Esarey, MS, EDS

Abstract

Prior studies of stress experienced by probation officers have focused on the negative effects of stress upon professional performance and personal and organizational health. This study identified probation officers recognized for their sustained performance and health and utilized individual questionnaires and focus group discussions to identify those strategies used to achieve and sustain such performance and health. The major stressors experienced by participants included role ambiguity, role conflict, role overload, challenges to personal and professional integrity, and difficulties managing personal-professional boundaries. Strategies used to successfully manage these stressors reported in survey questionnaires included the cultivation of certain qualities (e.g., sense of humor) and ideas (recognition of the limitations of the probation officer role); support from intimate and family relationships, peers within the work environment, and relationships in one's extra-work social network; and stress-ameliorating activities (hobbies, self-monitoring, exercise, professional training). Focus group discussions revealed additional strategies for performance and health enhancement: focusing on the positive, physical and emotional self-monitoring, acts of self-care, limit-setting, boundary management, centering rituals, mirroring rituals, and unpaid acts of service outside the work environment.

The Other Side of Burnout:
An Ethnographic Study of Exemplary Performance and Health among Probation Officers Supervising High-Risk DUI Offenders

Introduction

Probation officers play an ever-larger role in the American criminal-justice system, but this role entails exposure to stressors that can erode professional performance and personal health (Whitehead & Lindquist, 1985). Research on probation officer stress is meager compared to research on stress in other roles in the criminal justice system (e.g., police officers, correctional officers), but existing studies confirm that probation officers experience role ambiguity and role conflict, role safety concerns, low pay and promotional opportunities, excessive paperwork, lack of administrative/supervisory support, and lack of participation in organizational decision-making (Whitehead, 1985; Whitehead & Linquist, 1985; Brown, 1987; Holgate & Clegg, 1991; Lindner & Koehler, 1992; Linder & Del Castillo, 1994; Lindner & Bonn, 1996; Whitehead, 1987; Whisler, 1994; Slate, Wells, & Johnson, 2003). Probation officers experience added pressure when the decisions they make or fail to make affect public safety via injury to others from acts of violence, e.g., assault or alcohol and other drug-related crashes caused by those they supervise. Prolonged exposure to such stressors in the absence of stress-mediating supports can lead to stress-related health problems, excessive behaviors (e.g., risk-taking behavior), emotional problems, disengagement from or over-involvement in professional and personal relationships, and changes in basic values (e.g., cynicism) (White, 1997; Curtis, Reese, & Cone, 1990). At an organizational level such stressors contribute to job dissatisfaction, interpersonal and inter-unit conflict, and officer turnover (Simmons, Cochran, & Blount, 1997). The deterioration of personal and professional functioning resulting from prolonged contact with high-stress work environments has been described as “burnout” (Maslach, 1982), “compassion fatigue” (Figley, 1995), and “secondary traumatic stress” (Stamm, 1995).

Studies to date of probation officer stress have focused on the negative effects of stress on the individual officer and the health of the organization and have sought to extract proactive strategies to ameliorate professional stress. The current study utilizes a quite different approach. Over the years the authors have been struck by the existence of officers who, while experiencing the same stressors as their peers, maintain a remarkably high level of professional performance and personal health. Our goal in this study was to identify a group of such long-tenured superperformers and see what could be learned about how they managed the stressors of probation work in such an exemplary manner. Because of our concurrent involvement in multiple projects involving probation supervision of DUI offenders, we were also interested in studying superperformers whose caseloads included DUI and other high-risk offenders. It is our hope that this brief qualitative study of a small sample of high-functioning probation officers will stimulate additional studies of exemplary performance and health in the criminal justice system.

Methodology

The chief probation officers or supervisors in fifteen county-probation departments in Illinois were contacted by the Administrative Office of the Illinois Courts (AOIC) to solicit their interest in a study of exemplary performance among probation officers. All agreed to allow an officer selected by the AOIC to participate in the study. The fifteen county-probation offices included urban, suburban, and rural settings and spanned offices of varying size (from two to 124 probation officers). The officers chosen for inclusion in the study were selected by the two senior staff of AOIC responsible for monitoring probation departments in the state of Illinois. The AOIC monitors were in a unique position to nominate participants due to the longevity of their

direct work with these departments and their probation officers. Five criteria were used to select participants for study recruitment:

1) Longevity (at least three years' tenure as a probation officer)
2) A caseload that included offenders arrested two or more times for driving under the influence of alcohol or supervision of such cases
3) Exemplary performance (a sustained, high level of professional performance)
4) Positiveness (an attitude of optimism that has exerted a positive influence on probationers and professional peers)
5) Personal health (sustained physical, emotional, and relational health over the span of his or her career).

All fifteen individuals nominated were contacted in June/July of 2004 and consented to participate in the study. Participation in the study involved completion of an individual questionnaire (See Appendix A) and participation in a regional focus group. Fourteen of the fifteen people nominated completed the questionnaire and participated in a focus group. The age range of participants was 31 to 61 years with a mean of 42.2 years. The sample was 14% male and 86% female. Participants varied in years of probation experience (3 to 26 years with a mean of 12.9 years) and worked in different demographic settings: 64% rural, 21% suburban, and 15% urban. Seventy-nine percent of participants had completed a bachelor's degree and 21% had a master's degree. The range of DUI cases within the caseloads of participants ranged from 3% to 100%, with a mean of 21.1%.

The individual questionnaire completed by each participant included a demographic profile (age, gender, ethnicity, education, occupation) and open-ended questions about his or her experience as a probation officer, philosophy of probation work, and strategies utilized to maintain a positive approach to his or her work. The questionnaire also contained a list of professional and personal activities that participants rated as to their importance in their sustained performance and health.

Each person selected for the study also participated in one of four regional focus groups after completing the individual questionnaire. The focus groups were conducted in August 2004 and were facilitated by field coordinators of the Administrative Office of the Illinois Courts and by research staff from the Institute for Legal and Policy Studies at the University of Illinois-Springfield. Probation officers in the study were not paid for their participation but were reimbursed for travel expenses to attend the focus groups. Each focus group included an average of three to four participants, lasted approximately two hours, and addressed the following eight questions:

1. What characteristics distinguish the best probation officers?
2. What are the major stressors of working as a probation officer?
3. What special stressors exist in the supervision of high-risk DUI offenders?
4. How would you characterize the personal and professional self-care of most probation officers?
5. What special obstacles to professional and personal self-care exist for probation officers?
6. What strategies or techniques have you found to be most beneficial in terms of your own personal and professional self-care?
7. What advice would you give a new probation officer about how to be a good probation officer while maintaining his or her personal health?
8. What could the Administrative Office of the Illinois Courts and local probation departments do that would enhance the personal and professional self-care of probation officers?

Responses on the individual questionnaires were analyzed, and focus group interviews were transcribed (without names of participants) and analyzed for dominant themes and recommendations. The study design and informed-consent process was reviewed and approved by the Human Subjects Review Board of the University of Illinois-Springfield.

Results

The study findings are presented in five topical areas: traits linked to exemplary performance of probation officers, stressors of probation work, stressors unique to managing high-risk offenders, obstacles to professional self-care by probation officers, personal strategies for ameliorating stress and optimizing performance, and organizational strategies to enhance probation officer health and performance.

Professional Traits Linked to Exemplary Performance The stress in any occupational role is fundamentally a function of role-person match—the congruence between the demands of a particular role and the nature of the knowledge, skill, and temperament each individual brings to that role (White, 1997). When asked what characteristics were most crucial for exemplary performance by probation officers, respondents expressed a high degree of unanimity. First, they felt that preoccupation with financial wealth, public or professional recognition, and rapid career advancement were disqualifying factors due to the modest salaries of most probation officers, the public invisibility of the day-to-day work of the probation officer, and the limited feedback and career-advancement potential in most probation departments. Failure by many to recognize the nature of the probation officer role as a career choice was perceived as a potential source of stress and discontent. Second, they reported that the following characteristics were most important to prolonged success as a probation officer: maturity, tolerance, open-mindedness, flexibility, technical competence, self-confidence, patience, integrity, honesty, humor, and humility. When asked to describe the core values that guided their work as a probation officer, participant responses clustered similarly around the values of honesty, integrity, and respect. Focus group discussions centered on the need for compassion, the importance of a commitment to facilitating change in people's lives, and an understanding of how such change occurs. The ability to see the person beyond the offense was seen as crucial to effective probation work. Exemplary performance is built on an empathic recognition that, given different circumstances, the probation officer could be sitting in the probationer's seat. Considerable attention was also given to the ability to respond to the multiple role demands of probation work—demands in relationships with probationers, in relationships within the probation department and the larger court system, and in relationships with allied professionals and the public.

Probation Stressors Data from this study revealed three core stressors of probation work. The first stressor noted in the individual and group responses involved the role ambiguity and role conflict that is an inherent part of probation work. Respondents talked at length about the tension between their responsibilities to the courts and the public (monitoring and enforcement functions) versus their responsibilities to offenders (helping functions). The challenge of exemplary performance in probation work is the effective integration of these two quite different and potentially conflicting roles. This challenge is intensified by widely varying philosophies inside the criminal justice system and within probation departments regarding the ideal role of the probation officer. Probation officers are caught in the middle of cyclical philosophies of rehabilitation (the probation officer as a specialized social worker) and philosophies of "trail 'em, nail 'em, and jail 'em" (the probation officer as a specialized law-enforcement officer). This tension between these enforcement and rehabilitation functions leaves probation officers open to second-guessing and criticism. As one officer noted,

You feel the strain between the need for firmness and the need for flexibility. [As a probation officer] *you need to know when to be authoritarian and when to hold back a bit longer and let your client work something through. We operate with the constant awareness that we can be criticized for being too harsh or too lax in the management of any case.*

The second major stressor identified by respondents was that of role overload—excessive demands related to the quality and quantity of work expected within particular time periods. This stressor expresses itself as a tension between system demands (e.g., predictable deadlines for client visits, reports, and court appearances; unexpected emergencies) versus the needs of assigned probationers. Frustrations can easily arise when aspects of the former (e.g., endless waiting for court appearances) conflict with critical needs of clients (e.g., need for readmission to addiction treatment or admission to domestic-violence shelter services). Comments like the following expressed this strain.

I can have somebody's file pulled because they are a higher-risk person and I want to focus on his supervision and service needs, and then the sixteen stupid things that I shouldn't have to be dealing with at all come walking in the door. At the end of the day I realize that the one person I really should've been spending time with didn't get any time. That frustrates me because, let's face it, those are the cases that potentially are going to blow up in your face.

I had to work this past Saturday. I have so much to do that I can't get it done in my normal work hours, even though I try to protect my weekends for my family and close friends.

I understand budget cuts and counties being reluctant to pay for extra officers, but when I started our average caseload was about eighty and it's literally double that now, plus the increased expectations for home visits, additional documentation, and casework—all on a 100% felony caseload. You have this overwhelming number of cases to deal with, and if something goes wrong, you start wondering, "Could I have done something better before this client committed another crime?" Such issues can wear probation officers down.

Study participants noted the need to strike a balance between these multiple demands but emphasized the need to stay client-focused in that process.

. . . there certainly is the time factor to consider, and yet when I'm with a client, I want that person to believe that right then, they matter to me more than anything—that I'm listening to what they're saying, responding to what they're saying, and that I don't have one eye on the clock. And yet realistically, I have to keep them focused. It takes good training for a probation officer to have the skills to attend to that individual while managing the limited hours in the workday. It's a delicate balance.

Role-integrity conflict—incongruence between personal values and workplace values or challenges to one's personal integrity—was the third major stressor of probation work identified by study participants. This most often took the form of disrespect of their role or person from others within the criminal justice system, e.g., judges, states attorneys, and law enforcement officers.

The stress comes from the judge, the state's attorney, the police, the jail staff, and the county board. And the only times I ever get mad and want to say, "I'm outta here," is when

too many egos get in the way of getting something worked out. I really enjoy the job. . . . I can handle the probationer, but for the judge and the state's attorney and others to have expectations that we [probation officers] *can do things that we can't is frustrating.*

The need to understand the politics of probation work and the complex system in which probation work occurs was noted by most respondents. The following comment is typical.

I find the frustrations generated by the bureaucracy most stressful. As soon as politics come into play, it drives me nuts. And there is the constant funding crisis and worry about where we are going to get money for this and how are we going to do that.

There was considerable discussion on the importance of probation officers individually and collectively establishing mutual respect within the multiple professional relationships inherent in probation work. As one participant noted, "The key is to find out what makes each judge or state's attorney tick and what makes the person respond well to you."

Challenges to the integrity of probation officers can also come from family members of offenders and victims as well as the public.

We get calls from family members, neighbor, or victims wanting to report some concern about a probationer. They demand, "Why aren't you people doing something?" Probation officers are blanketed within this "you people" category. It is not an endearing term. When we try to explain what we can and can't do in response to such complaints, they have difficulty understanding the legal limitations we operate under.

The problem of spillover from these role stressors—the leakage of professional stress into one's personal and family life—was raised as a concern in all of the focus groups. The following comments are typical.

Most probation officers' lives are kind of chaotic due to the size of our caseloads and the nature of who we have to deal with. It's hard not to reduce everything to self-preservation, routing people without getting in-depth, just to survive. At a personal level, I think most officers stay pretty closed up—like police officers. What do you do—go home and tell your wife or husband about the child abusers and rapists you saw in the office today? It's difficult for officers to not carry their work home and yet difficult not to be able to talk about it there.

There is a danger in getting caught up in negativity. A lot of our day is spent with negative people, and being caught up in all this negativity can really weigh on you. Sometimes you just want to say, "Why do I even bother." That negativity can poison your work life and your home life.

There are a lot of times I come home from work and I wish I didn't know so much about what goes on behind people's closed doors. Sometimes I would like to not know what's going on in the world. I just want to be in my own little house, my own little family, and deal with my own stuff, and not have to think about who's abusing who down the street.

In the discussions of probation officer stressors, several things were striking in their absence. First was the lack of stressors identified in working directly with criminal offenders. (The only exception was stress in working with probationers that posed a high risk to the community. See further discussion below.) This is congruent with other studies that have found that most stress experienced by probation officers is unrelated to direct contact with their clients

(Whitehead, 1987). Also striking was the lack of concern expressly related to role safety (threats to the physical or psychological safety of the probation officer) or role security (threats to the stability of future employment). Concerns about role safety arose only in one focus group in reference to home visits in southern Illinois to probationers dependent upon methamphetamine or involved in its manufacture.

Stressors with High-Risk Offenders When asked about particular stressors in working with high-risk DUI offenders (recidivists or individuals judged to be high risk for re-arrest or future alcohol-related crashes) and other high-risk groups (e.g., sex offenders, domestic-violence offenders), respondents focused on the visibility of such cases.

> *You feel intense pressure because you have such a responsibility to the community. These high-risk offenders pose such a potential threat to public safety that you feel pressure to find the right treatment for this person and to make sure that they're getting something out of it.*

> *I think the intensity of the risk and the fact that progress* [with high-risk offenders] *is measured in such baby steps puts enormous pressure on probation officers. One little mistake and you're on the front page.*

Supervising high-risk offenders was described as working in a fishbowl, with multiple parties watching and judging what the probation officer does or fails to do. Such accountability clashes with the illusion of normalcy of such offenders.

> *Many of these [DUI] offenders are functional people in society. They have a stable job and a family and some social standing. So it's a little bit different than the rest of the population that we have on probation. . . . And alcohol is such an accepted drug because nearly everyone consumes it and has driven under its influence at one point in their life. It's hard for the system and sometimes for us to see the DUI offender as a criminal—and yet they kill people.*

The apparent normalcy of many high-risk DUI offenders can lead to lax supervision, requiring probation officers to constantly remind themselves of the public-safety stakes involved in their work with these offenders. The failure of the criminal justice system to see the DUI offender as a criminal contributes to probation officer frustration in seeing such offenders who have multiple DUIs (and sometimes multiple treatment-episodes) but who have managed to escape any significant punishment for their continued threat to public safety. In the absence of more significant sanctions the probation officer stands alone as the barrier between the DUI offender and his or her future threat to public safety.

Respondents also talked at length about the difficulty and slowness of the change process with high-risk offenders, particularly the high-risk offender's denial or minimization of their problems, the challenges of getting them to and through treatment experiences, and their propensity for relapse.

When the exemplary performers in this study talked about taking work-related stress home with them, it was almost always in the context of worry about a particular offender's threat to others. The following is typical of such concerns.

> *The worst weekend I've had on this job was when I found out late on a Friday afternoon that the jail had released a guy at least two months earlier than he should've been released. I spent the whole weekend worrying whether he was going to kill his ex-girlfriend. When I pointed out to the jail and the state's attorney that he was released too*

early, nobody seemed to care. But, you know, that was a guy that I should've been paying more attention to in the weeks before he got out of jail and making sure that everything was set up for him.

Obstacles to Self-care Study participants did not identify many unique dimensions to self-care that distinguished probation officers from other occupations. They did talk about the cynicism that often pervades the criminal justice system and the almost contagious quality of such cynicism. Such cynicism was part of the "reality shock" that marked their entry into probation work.

I don't think I know if I was a positive person or a negative person when I first started. I just knew that when I got in, I saw a lot of what I didn't want to be. I looked around and I thought to myself, "If I stay, I hope I'm not like that."

A second obstacle to professional self-care noted by focus group members was the limited access to outside professional training afforded to probation officers. Such limitation was thought to stem from the fact that training was one of the first things to be cut in the current wave of fiscal austerity measures and from the misperception that probation work requires less technical training than other professional roles.

The obstacle to self-care that received the most prolonged discussion in the focus groups was the lack of personal/professional separation in rural communities. The following comments illustrate the difficulty of leaving one's work at work in such settings.

In small communities, we are all interconnected. It brings a different kind of accountability. You can't just go home and forget about it because your neighbors are the people you are working with or know your clients. My husband will come home and say, "So-and-so's out of jail," and I'll say, "No, he's not due for release yet," and he'll say, "I just saw him in a car with his mother screaming at her about wanting money."

I can be in the grocery store or at a Little League ballgame with my family and one of my clients will come up to me and ask, "Do you remember when my next appointment is?" Or I'll walk into the Dairy Queen and a client will announce to the world, "There's my probation officer." And they tell us we're supposed to worry about confidentiality! Sometimes you get sucked back into your job at a time and place you're not expecting it.

Probation officers, particularly in rural communities, may also be held to a higher level of expectations related to their personal and family life. One participant explains:

You think to yourself that you can't go out in the community and unwind quite as much as other people, because when you go out into the community, people know you and watch you. Y*ou're not just expected to be a positive role model from eight to five; we live with expectations that are 24/7.*

Self-care Strategies

Information on professional self-care strategies of exemplary performers in probation work was obtained in two ways. First, each study participant was asked to rate each item in a list of professional self-care strategies (drawn from the professional literature) based on each strategy's degree of importance in maintaining the worker's health and performance. The rating options were 1 (not important), 2 (important), and 3 (very important). There was a high degree of variability in ratings, with each of the seventeen items being ranked as very important by at least one participant. The average ratings for the seventeen items are displayed in Table 1. The

highest-ranking strategies involve the cultivation of certain qualities (e.g., sense of humor), relationships (intimate and family relationships, supportive relationships within the work environment, and supportive relationships in one's extra-work social network), and activities (hobbies, self-monitoring, exercise, attending training).

Table 1: Professional Self-Care Strategies

Average Rating	Stress-reducing Activity
2.857	Cultivating a sense of humor
2.857	Having healthy intimate and family relationships
2.714	Having one or more close relationships at work in which I can express emotions related to my work experience
2.714	Having enjoyable hobbies/leisure activities
2.571	Maintaining relationships with professional peers who work outside the criminal justice system
2.571	Having one or more close friendships away from work in which I can express emotions related to my work experience
2.571	Avoiding or self-monitoring potentially harmful approaches to stress management (e.g., smoking, drinking, risk-taking, cynicism, and negativity)
2.5	Physical self-care (e.g., healthy diet, regular physical checkups)
2.5	Attending professional training
2.439	Cultivating relationships with other POs who have a positive attitude
2.429	Having alone-time rituals that keep me focused (e.g., meditation, prayer, self-reflection)
2.428	Getting regular exercise
2.071	Maintaining relationships with POs who work in other offices
1.928	Daily goal-setting and/or self-evaluation at end of the day
1.857	Having one or more professional mentors
1.857	Doing volunteer work unrelated to my job
1.714	Using particular stress-management techniques (e.g., biofeedback, meditation, progressive relaxation)

Participants in the focus groups were also asked to describe the strategies of personal and professional self-care that had contributed to their health and productivity. The following strategies were among those discussed.

A. Focusing on the Positive—The stressors experienced by the exemplary officers in this study are offset by satisfactions that they reported experiencing. What participants liked best about probation work was their experience of making a difference to individuals, families and communities; the diversity and challenges of their professional duties and experiences; depth of knowledge about the community; and the autonomy and creativity they are afforded in developing one's own style of doing probation work.

B. Self-monitoring—Study participants felt that health and exemplary performance were not permanent achievements but states that had to be constantly monitored and renewed. They viewed self-monitoring and a highly personalized adaptation to the probation environment as the foundation of sustained health and performance.

I had to learn to listen to myself. Our minds and our bodies tell us what we need to do, but we just don't listen. When we aren't taking care of ourselves, our body, our thoughts, our emotions will tell us.

We have to follow our instincts. If we listen to ourselves, we know what we need to do. Even in decisions we make on the job. When I first started as a probation officer, I felt like a fish out of water because it was so different from what I had been doing. I was listening to what everybody was telling me and trying to incorporate all of those things into the way I was trying to do my job, but it didn't work very well. What I had to do was find my own way. I got a lot of good advice, but I had to put it together with what worked for me by listening to myself.

C. Acts of Self-care—Exemplary performers in probation work take care of themselves via exercise, healthy diet (although there was considerable discussion about the medicinal power of chocolate), and protecting time with family and friends. When they recognize that they are feeling distressed, they utilize a wide variety of decompression rituals that range from short time-out periods (getting outside, taking a brief walk, positive self-talk, and emotional self-expression to peers, a supervisor, and family and friends) or more extended breaks from the work environment.

Humor has a special place in probation work. There is cynical, cutting humor and humor that is liberating and healing. Our exemplary performers talked at length about the importance of the latter.

We [probation officers] *are like a lot of high-stress professions in our propensity for gallows humor. We have this warped way of looking at things. We'll laugh at something that people who don't work in this field would never laugh at. It's a protective device that helps us deal with a lot of strong emotion.*

It's the stupid things that I do in the office that embarrass me and all the things other people do that embarrass them. It's the ability to laugh at ourselves that keeps us healthy.

If I don't laugh about some of the stuff that goes on in our world, I'm gonna cry about it. You have to be able to turn some things that are difficult to handle into laughs.

Positive self-talk took a variety of forms but included self-reminders that the probation officer works within a flawed criminal-justice system—one that due to excessive demands and limited resources will always be flawed. Being able to accept the imperfections in the criminal justice system and one's limited role in that system was viewed as critical to long-term effectiveness and health as a probation officer.

Reminding myself that I am only a piece of this larger pie and that I can only be responsible for my own part helps keep me level and healthy.

The importance of time-out periods was noted by numerous participants. The following comments are representative.

When it gets too much, I get up and leave my office and walk outside or walk to the car. Sometimes I will get on the computer and check out the news for a few minutes. I get to a point I just have to take care of my own needs, and then I can come back to the work stuff and look at things differently and with a fresher perspective.

One thing that helps keep my sanity is that I always try to have something to look forward to. It doesn't have to be anything major, but it has to be yours. I try to have something each day—something within a relatively short-term time, something within the week, something on the weekend, or something that evening to look forward to. If you always have something that is personally yours to look forward to, you can deal with about anything.

My son, husband, and I, we plan a weekend trip every weekend. We are fortunate enough to live by a lot of the state parks, so we go to all of the different parks. We have a goal that every weekend we will explore something new as a family. That time is personally reenergizing.

To reduce the spillover of professional stress into their personal and family lives, exemplary performers also utilize demarcation (transition) rituals that allow them to close off their work life each day and reenter their personal lives. This can involve maintaining perspective on the relative importance of one's work in relationship to one's whole life (as noted in the three responses below).

It's also important to remind yourself that it's just a job. You can get wrapped up in somebody's problems to the point they become your problems. You have to remember that you're not a part of it and must maintain your separation if you are going to be of help.

I think the healthiest probation officers find a good balance between their professional lives and their personal lives. They're not living only for work or only taking care of themselves and their families and doing nothing at work. They can work hard and then go home and leave it behind them and focus on other people and activities.

When the day is done, you gotta leave it there.

This strategy can also involve particular transition rituals done at the end of each workday to prevent carryover of work stress into the home. Several study participants reported using their commute time home from work for such separation.

D. Limit-setting and Boundary Management—Exemplary performers achieve a high degree of productivity, but they sustain that productivity by carefully limiting their commitments. Study participants, because of their recognized productivity, had to regularly reign in their propensity to overcommit themselves in response to requests to take on additional responsibilities. The ability to manage their workload seems to have been a key to long-term performance. This group of exemplary performers also found ways to define and maintain the boundary between their personal and professional lives. The need for such boundary management generated considerable discussion.

Our church takes a bus to the treatment facility in our town and brings them to our church. I've got a large clientele at church now, and I've really had to learn how to manage that. My clients all want to come up and talk to me there. I want them to know that I'm glad to see them there, but I will not talk business with them there. I've had to learn to say, "Gimme a call on Monday and we'll talk about that."

While you're at work, you take that stuff personally and you do what you can do there. Then it's back to your family, and that's your family's time and it's not fair to them to bring

your work home to them. I don't know if it's easy for other people to do that, but I've had to learn to leave work at work.

One of the techniques that I use is to try my best not to take my work home with me. I try to leave work behind and enjoy time with myself and my family. Whether it's playing golf, reading books, or going to the movies, you have to do those things that replenish you. If you get yourself into a rut of just going home and getting up and going to work, you're gonna have a tough time staying positive at work.

E. Centering Rituals—One particular category of self-care utilized by these exemplary performers was the use of centering rituals—rituals that reaffirm one's core identity and core values (White, 1997). For some this involved the arenas of religion and spirituality.

I focus on getting totally away from the job, doing something that's completely unrelated. Right now I'm in the oblate program with the Benedictine nuns, and I get a lot of enjoyment out of spending time at the monastery. It is very peaceful and restful there and helps me deal with the stress.

I think that the spiritual aspect of a probation officer's life can help, and I'm not saying it has to be one particular religion. It may not have to be religion at all, but just having some type of spiritual element to your life helps you get through with what you have to deal with on the job.

For others these centering rituals involved finding activities that reaffirmed the existence of goodness and decency—an antidote to the confrontation with negativity and pain that is so much a part of probation work.

I really push myself to spend time with the good people in the community. If you're dealing with people who are criminals during your workday, some part of the rest of your time needs to be spent with prosocial people. I think that helps me to keep aware of the fact that most people who live in the community are decent. To keep from getting cynical and jaded, I have to do things that prove that to myself.

There's a little thing that I have done for probably the last ten years, and some people may think it's corny, but I live by it. There's this little calendar that has five things to be happy about every single day. So every single day the first thing that I do is go down and pour my coffee and look at the five things for that particular day. Some of them are pretty goofy, but there's always one out of the five that usually connects to me. I make a conscious effort to start every single day all over again with a fresh new perspective.

F. Mirroring Rituals—Mirroring rituals involve cultivating relationships that reinforce one's aspirational values and avoiding people who represent the antithesis of those values.

There are times when we're emotionally down or emotionally up, and there are some people who are constantly negative or positive. It's really important for us to recognize, and I think we do it intuitively, who's gonna suck the energy and positive stuff out of us, and who's gonna help rejuvenate us. I try to spend as much time as possible with the positive people.

I ask those who are constantly negative, "Why do you work here." I get tired of hearing "I'm here for the benefits" or "I need to pay the bills" or whatever. You can get benefits somewhere else. I stay away from them as much as possible.

It's hard to confront the negativity for fear of being calling a cheerleader or a Pollyanna or accused of kissing up to management. It's easier to just surround yourself with really positive people and avoid the others.

If I'm frustrated at work with something, I seek out people—a coworker or my boss—that I feel like I can talk to about it and who can give me good feedback. So it's not just a gripe session, but it's a let's-solve-the-problem session. That really helps when I can't deal with it on my own.

The new probation officers coming in have something to teach us. When we've done this for a while, we can lose some of the good qualities we had when we started. New officers can get us back in touch with those qualities. Clients can also help. I've learned that if you really respect and listen to your clients, they will tell you what's going on, but you have to listen.

Some participants described how they had ritualized these mutual support rituals within their offices.

If there's somebody in our office starting to get stressed out, we take them out to lunch. Food resolves all problems. [Laughter] *It's a time to unwind and relax and talk about work or things going on at home. It's all about working together as a whole.*

G. Unpaid Acts of Service—Several participants described unpaid volunteer work outside of the probation field as a means of sustaining their health as a probation officer.

I volunteer for the local YMCA, where I teach a class for two- and three-year-olds. I find such activities rewarding for me and a break from so many negative things I see in the probation part of my life.

Performing acts of service in one's personal life would not on the surface seem to offer a source of replenishment from high-stress service occupations. The exemplary performers we studied tended to use these activities to reinforce their identities as people who were making a positive difference in the world and to give something positive to their communities outside the framework of paid employment.

Organizational Approaches The exemplary performers in this study felt that there were several organizational strategies that could help optimize the performance and health of probation officers. Many praised efforts at health promotion that some counties and court systems had initiated, but they also emphasized the positive role of office policies (e.g., flex time), in-house training and team-building, and the quality of supervision. Ideally, they envisioned a chain of support through which they were supported in ways that allowed them to effectively monitor and support those they served. There was considerable discussion about the importance of the overall work milieu and the importance of the supervisor in enhancing health and performance. The following comments are representative.

I don't think you can expect your officers to care about the people they're dealing with if you don't care about them. We don't raise caring kids by being nasty adults, and you are not going to have an office with caring officers if supervisors don't care for them.

We've been so lucky to have a great supervisor who then became the director. I had a friend in the hospital, and he kept looking at me and saying, "What are you doing here? Your work will be here tomorrow, and you better not be. This is why we give you sick time and vacation time. We can cover for you." When you get that kind of support, you are ready to work twice as hard when you come back.

We have one officer with a son with special needs, and when he has to leave, we all are comfortable walking into court and saying, "I'm sorry, he's had to leave, can we continue this," or "I will be reporting on their behalf."

Study participants suggested that chief managing officer training that focused on how to create and sustain a positive working environment could be very helpful in elevating performance and health within particular probation departments. Other suggested ideas included formal mentorship programs for new officers and refresher courses for more tenured workers (after ten years) that focused on personal and professional development.

Discussion

This study examined stressors and stress management strategies among probation officers who have sustained high levels of professional performance and health. The stressors identified by study participants included such conditions as role ambiguity, role conflict, and role overload that have been identified in earlier studies of probation officer stress (Whitehead, 1985; Lindner & Koehler, 1992; Whitehead, 1987; Whisler, 1994; Lindner & Bonn, 1996) but included a greater emphasis on the special difficulties probation officers experience in trying to achieve a separation between their professional and personal lives.

There have been two central theories about professional burnout: one attributing the source of worker distress to prolonged contact with clients (Maslach, 1982) and another arguing that the source of such distress derives more from factors in the organizational environment (Chernias, 1980). Whitehead (1985) tested these theories in the probation environment and found that most probation officer stress was rooted more in the lack of organizational support for the probation officer than in stressors the probation officer experiences in relationships with his or her clients. Our study supports Whitehead's findings. With the exception of stress related to the potential threat to public safety of a small subset of high-risk offenders, the probation officers in our study did not report client contact as the major source of their professional stress. In fact, most of our respondents cited such contact as a source of professional satisfaction. The stressors they reported experiencing most frequently and most intensely related to the organizational conditions within which those service relationships were conducted.

The strategies used by study participants to elevate and sustain their performance and health are widely recognized in the classic stress-management literature (e.g., Selye, 1974; Pelletier, 1977) but contain qualitative differences. Two examples are particularly noteworthy. There is a substantial body of literature on the use of professional mentors to enhance the health and performance of human-service workers (see Sosik & Godshalk, in press), but this particular strategy ranked fifteenth of seventeen strategies that participants were asked to rate in personal importance. Similarly, formal stress-management techniques occupy a central place in the stress management literature but ranked least important of the seventeen strategies rated by the probation officers in our study. Also noteworthy is the prominent role that relationships played in ameliorating stress. Five of the top seven strategies used by our superperformers to manage

professional stress involved drawing support from relationships outside of or within the work environment.

This study also sheds some light on the particular style of stress management that superperformers utilize to sustain their performance. When asked how they responded to being angry, depressed, frustrated, or exhausted at work, our respondents consistently described an assertive response to such feelings. Rather than project blame for these emotions, the exemplary performers examined how these feelings related to their own behavior, took personal responsibility for those feelings, and then took proactive action to change them. Given the choice to respond to stressors emotionally, cognitively, or behaviorally, the super-performers in our study exhibited a marked preference for action.

There were several limitations to this study. As a pilot study, the small number of participants precluded quantitative analysis and the identification of variance in responses by age, gender, ethnicity, tenure of experience and caseload mix. The small study-sample contained an unrepresentative proportion of Caucasian female probation officers from rural areas—a sampling bias that may have shaped the character of our findings. The study lacked a comparison group of probation officers who had experienced sustained performance problems and health problems. (Use of a comparison design was not politically or practically feasible.) The study design was also hampered by the lack of objective criteria to define exemplary performance and health. Future studies would also benefit from the inclusion of measures related to job satisfaction. While job satisfaction was not a specific focus of this study, the interaction of productivity, health, and professional satisfaction was a clear theme within the focus group and questionnaire responses—a finding that confirms earlier studies (Wright & Bonett, 1997; Wright & Cropanzano, 2000).

Notwithstanding these limitations, the study has several strengths. It is one of the first studies to use a resilience framework (versus a pathology framework) to study probation officer stress. We hope that there will be future studies of larger size and greater methodological rigor that focus on exemplary performance and health of probation officers. The study also provides one of the most in-depth descriptions in the professional literature of how probation officers sustain high levels of performance and health. There have been many studies of professional distress and its effect on health and performance. This study marks a shift from studying the problem to studying the lived solution. It is, as such, a study of stress (sustained demands for adaptational change) without distress (deterioration in personal health and professional performance). Studies that focus on the negative aspects of professional stress can mask the fact that there are professionals who thrive in these very conditions. We have tried to open a window of understanding into such professional resilience.

Recommendations for Follow-up

We would offer the following recommendations as potential follow-up activities to this study:

1. Distribute a copy of this study to the chief managing officers of all probation departments in the state of Illinois.
2. Explore the possibility of conducting a larger survey of exemplary performance and health of Illinois probation officers, utilizing quantitative measures of the performance and health and quantitative measures of strategies linked to these conditions.
3. Integrate the findings of this study into the orientation of new probation officers in the state of Illinois.
4. Conduct two workshops in Illinois for CMOs and their leadership teams on enhancing exemplary performance and professional health in probation services.

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Acknowledgement: This study was supported by a grant to the University of Illinois at Springfield Institute for Legal, Administrative, and Policy Studies from the Illinois Department of Transportation. The opinions expressed here are those of the authors and do not represent

opinions or policies of the Illinois Department of Transportation or other Illinois State agencies. We would like to also acknowledge the assistance of Ralon Marchell and Tim Feeney in transcribing the recordings of the four focus groups.

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Appendix A

Administrative Office of the Illinois Courts Focus Groups on Self-care Patterns among Probation Officers Supervising High-Risk DUI Offenders
Participant Information Sheet

What do you like most about being a PO?
What do you like least about being a PO?
How would you describe your personal philosophy of probation work?
What core values guide your work as a probation officer?
What activities do you do on a regular basis at work to sustain a positive approach to your work?
What activities do you do on a regular basis outside of work to sustain a positive approach to your work?
Briefly describe what you do in response to the following:
When I am frustrated at work, I . . .
When I am angry at work, I . . .
When I am sad or depressed at work, I . . .
When I feel professionally exhausted or stagnant, I . . .
When I'm disappointed by the failure of someone I'm supervising, I . . .

Rate each of the following on the positive influence they have exerted on your performance as a probation officer.

1 = not important
2 = important
3 = very important

___ Attending professional training
___ Having alone-time rituals that keep me focused (e.g., self-reflection, meditation, prayer, or reading that is informative and motivational)
___ Daily goal-setting and/or self-evaluation at end of day
___ Cultivating relationships with other POs who have a positive attitude
___ Maintaining relationships with POs who work in other offices
___ Maintaining relationships with professional peers who work outside the criminal justice system
___ Having one or more professional mentors
___ Having one or more close relationships at work in which I can express emotions related to my work experience

___ Having one or more close friendships away from work in which I can express emotions related to my work experience
___ Having healthy intimate and family relationships
___ Having enjoyable hobbies/leisure activities
___ Avoiding or self-monitoring potentially harmful approaches to stress management (e.g., smoking, drinking, risk-taking, cynicism,
and negativity)
___ Getting regular exercise
___ Physical self-care (e.g., healthy diet, regular physical checkups)
___ Using particular stress-management techniques (e.g., biofeedback, meditation, progressive relaxation)
___ Cultivating a sense of humor
___ Healthy intimate/family relationships
___ Doing volunteer work unrelated to my job



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: The State of the Movement: Some Brief Reflections. Presented at the FAVOR Recovery in Action Summit, September 6, 2005, Washington D.C. Posted at **www.williamwhitepapers.com**

The State of the Movement

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I want to begin by acknowledging the incredible work that Pat Taylor and all those involved in FaVoR have done in making this Recovery Summit possible. It is a great honor for me to be asked to welcome you and to share a few brief opening thoughts about the state of the new recovery advocacy movement in America. Before I had the pleasure of working with William Cope Moyers, I was interviewed by his father, Bill Moyers, for a 1998 PBS special some of you will recall entitled *Close to Home: Moyers on Addiction*. In that interview, I lamented the restigmatization, demedicalization and recriminalization of alcohol and other drug problems and predicted the rise of a new recovery advocacy movement in America. At the time, that statement was more hope and prayer than prediction. Today, that movement is a vibrant reality in communities across the country, and our presence here today is living proof of that movement's birth and growing strength and geographical reach. The vibrancy of that movement is also evident in the rapid response of your organizations to the needs of recovering people displaced by Hurricane Katrina this past week. When word went out of the need for resources ranging from sober housing to recovery literature, responses poured in from across the country within hours.

Effective social movements become many movements, and we reflect that truth. We are a policy advocacy movement that is taking on issues of discrimination, social justice and service access. We stand for the proposition that addicted people and their families need to be embraced within systems of compassion and care rather than sequestered within systems of punishment and control. We are a public and professional education movement. We are building anti-stigma campaigns, and we are trying to push addiction treatment from an emergency room model of acute intervention to a model of sustained recovery support. We are a recovery research movement. We are a recovery celebration movement. We are an outreach movement delivering messages of hope to the very heart of this

country's cultures of addiction. We are a post-treatment recovery support movement—a housing movement, a jobs movement, a back-to-school movement, a health maintenance movement. We are a movement whose vision is to transform communities across this country into recovery sanctuaries. We are many movements.

What these movements are doing collectively is pushing this country's response to severe alcohol and other drug problems from a pathology paradigm and a treatment paradigm to a recovery paradigm. Let me explain this shift with a brief story.

Some years ago, I arranged to interview a number of old-timers about the early history of treatment in the Southwest, and was fortunate to have a number of people with decades of sobriety and a lot of direct knowledge of the relationship between early AA and treatment in the Southwest. When we took a break in the interviewing Searcy W., the oldest of the old-timers, asked, me, "Bill, what is this research stuff you are involved in?" I explained that I helped conduct treatment follow-up studies with people after they left treatment and proudly noted a few of our studies that were following people out as long as five years after treatment. He mused, "Five years? Very impressive," and then asked me, "What does your research tell you about characters like us (waving his arm to embrace the listening old-timers)? It was a stunning question. I had to admit to him that from the standpoint of science, we knew almost nothing about long-term recovery. Searcy's probing question haunted me in the weeks following my visit and led to my eventual resolve that whatever time I had left in my career would be dedicated to the study of recovery.

As a culture, we fill whole libraries with knowledge about psychoactive drugs, addiction, and addiction treatment. The problems of addiction are dramatically visible, but the solutions remain invisible and the best kept secrets in the country. We are here today to declare that it is time we honored and studied the solutions to these problems found in the lives of millions of recovering people all over this country and that the lessons learned should be used to widen the portal of entry into recovery. That shift in paradigms has begun as a result of the new recovery advocacy movement and is one of our most historically significant accomplishments to date.

New grassroots advocacy organizations are being formed every day and many of our organizations are growing in size, influence and effectiveness. The fact that the new recovery advocacy movement is coming of age means that we will face the struggles that characterize all successful social movements. An action agenda is emerging that includes some of the movement's most important internal issues. I offer these thoughts not as the last word on these issues but as an open invitation for our discussions in the next few days.

We're going to have to continually back up and regenerate consensus on the core ideas and public messages that will serve as the foundation of this movement. We must guard against the corrupting influence of government and private money in this process by keeping our eyes on the prize of recovery and not exclusively on what ideas and programs are fundable. We have to find ways that the recovery community itself can assume a central role in providing the time, talent and financial resources that will sustain this movement, and we have to bring diverse elements of the recovery community to define our core ideas and strategies. Ironically, generating consensus on a definition of recovery may be the most difficult part of building this conceptual foundation. The proposition that there are multiple pathways to recovery has been one of our key kinetic ideas. It is time for us to

define *recovery,* chart those pathways and then protect this precious concept from commodification and commercialization as the movement spreads and matures.

We are facing decisions on how to transition from local grassroots organizations into a national movement and there is the inevitable question of which national organization should represent this movement. The agendas emerging within this movement are so diverse it is possible that no single organization could effectively represent all of them. The NAACP, Urban League, SCLC, CORE and SNCC all contributed to the successes of the civil rights movement. We already have multiple organizations working for us at a national level. This is not something to be mourned but evidence of our coming of age. Given the diversity of recovery communities in the United States, a single national recovery advocacy organization is unlikely and perhaps not even desirable. We need FaVoR, NCADD, the Johnson Institute, the Legal Action Center, CSAT's RCSP, the National Alliance of Methadone Advocates and others, but we must also have the leaders of these organizations talking to one another and defining common ground on days our multiple movements must stand together.

We are facing questions about whether recovery support services should be integrated in to the existing treatment system or should be delivered through freestanding organizations. I think at this point in time we need to do both and rigorously evaluate both models. This issue should be decided not by bias or institutional interests but by scientific studies that answers the question of which models generate the highest rates of successful recovery initiation and maintenance and whether these outcomes differ across different populations of people seeking recovery. We need to codify these emerging models and subject them to scientific studies and to the scrutiny of community Elders who carry the history and wisdom of our communities.

We are facing questions about how to transfer ideas and replicable advocacy and recovery support programs from one community to another. We may eventually need recovery advocacy support centers whose charge will be to describe and transfer our emerging technologies and train new recovery advocates and recovery coaches. FaVoR, NCADD, the Johnson Institute and CSAT's RCSP have all helped provide some of this connecting tissue to date, but the need for information exchange, training and technical assistance outstrips the current capacities of all of these organizations. Perhaps it is time CSAT's Addiction Technology Transfer Centers became Recovery Technology Transfer Centers and broadened their mission to include the dissemination of emerging models for designing and delivering recovery support services.

As we are coming of age, we are also becoming more visible. Our growing numbers and influence will render us targets of powerful political and economic interests. Threatened interests from treatment agencies to the alcohol industry will seek to influence us, colonize us and, in some cases, discredit us. We need to develop protective shields for our organizations and our leaders. We need to examine our own internal vulnerabilities and make sure everything from our personal conduct to our finances can pass close public scrutiny. We need guidance on how to negotiate our way through the world of hard-core politics without losing our founding vision and core values. We must build broad community constituencies to enhance our power and protect ourselves.

As a movement, we face many needs, but perhaps none more critical than that of leadership development and succession. Some of the first generation of

recovery advocates entered this avocation late in our lives and some of the younger advocates are getting pretty battle-scared and warn out. We have advocates that with guidance will be ready for local leadership. We have local leaders ready to rise to the level of state, regional or national leaders. We have aging leaders disengaging from this movement whose contributions need to be honored. It is time we began to think about development of a recovery development institute that can nurture future leaders at all levels of this movement. Our leaders need to understand the tendency of stigmatized groups to elevate individuals to leadership and then undermine and scapegoat their leaders, only to later deify the most successful of such leaders. Leadership in historical hindsight looks pure and noble. In the present tense, it is messy and involves imperfect individuals and organizations involved in what are often primitive processes. Our leaders need to understand such processes. It is time we took seriously the challenge of leadership development and the need for succession planning. And in this process, we need to affirm the many roles family members are playing in this movement. It is time we welcomed family members as equal partners in the leadership of this movement.

There are some very important ideas that have emerged early in this movement, but I think none more important than the metaphor of the healing forest that Don Coyhis and White Bison have spread across the country. I think this powerful metaphor far transcends the recovery advocacy work in Indian Country and offers us a vision for the future of this movement. We will continue to find ways to carry a message of hope to those individuals and families who are still suffering, but it is also time we brought the recovery message to whole communities across this country. We need all of our communities to become healing forests.

In closing, I want to say how inspired I have been to witness the work of so many local recovery advocacy and recovery support organizations around the country. You are my heroes and heroines, and I have tried to honor your work as I have talked and written about this movement. We have entered a cultural window of great vulnerability and great opportunity. What we do or fail to do in the next few years will shape the history of addiction recovery in America for much of the twenty-first century. If there was ever a time for sustained recovery activism, it is now. As we participate in shaping that history, I hope we will hang on to one overriding vision for our movement: RECOVERY BY ANY MEANS NECESSARY!



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Laudet, A, Morgen, K. & White, W. (2006) The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, 24(102), 33-73. Posted at **www.williamwhitepapers.com**

The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use.

Abstract

Many recovering substance users report that they stopped using because they wanted a better life. The road of recovery is the path to a better life; it is a challenging and stressful path for most. There has been little research among persons in recovery in spite of the numbers involved, and most research has focused on substance use outcomes. This study examines stress and quality of life as a function of time in recovery, and uses structural equation modeling (SEM) to test the hypothesis that social supports, spirituality, religiousness, life meaning, and 12-step affiliation buffer stress toward enhanced life satisfaction. Participants were recovering persons (N = 353) recruited in New York City, mostly inner-city ethnic minority members whose primary substance had been crack or heroin. Longer recovery time was significantly associated with lower stress and with higher quality of life. Findings supported the study hypothesis; the 'buffer' constructs accounted for 22% of the variance in life satisfaction. Implications for research and clinical practice are discussed.

KEYWORDS: Recovery, Addiction, 12-step, spirituality, social support, quality of life

GLATTC Bulletin Special Edition
Recovery Month September, 2006
Great Lakes Addiction Technology Transfer Center

Alcohol, Tobacco and Other Drug Use by Addictions Professionals: Historical Reflections and Suggested Guidelines

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Abstract

Alcohol, tobacco, and other drug (ATOD) use by individuals working in the addictions field has existed as a complex, controversial personal and professional practice issue for more than 150 years. The central debate within this history involves the concept of nexus—the boundary that distinguishes rights to personal privacy from professional duties and obligations. Ambiguities related to this point of demarcation have contributed to misjudgments related to ATOD use by addictions professionals that have injured multiple parties. This essay reviews the history of ATOD use as a professional practice issue in the addictions field; discusses clinical, ethical, and legal issues related to ATOD use by addiction service professionals; and offers guidance on ATOD use decision-making.

Introduction

I entered the addictions field in the 1960s as a "streetworker" and aspiring "drug abuse counselor" at a time when few guidelines existed concerning the alcohol, tobacco, and other drug (ATOD) use decisions of service practitioners. Nearly forty years later, ATOD-related decisions remain an ambiguous and conflict-ridden area of personal/professional decision-making for preventionists, counselors, and others who work in the addictions field. Personal misjudgments within this arena have injured and ended careers, injured the reputations of addiction treatment institutions, and created a perceptual barrier that prevented individuals and families from seeking needed services.

In spite of its potential importance and its connection to the central mission of the field, ATOD use has existed only in the shadows of professional practice discussions. The subject is rarely broached inside service organizations and invisible in the field's professional journals and conferences. Knowledge of staff who have been disciplined or discharged for ATOD-related behavior and the circumstances surrounding such actions exist primarily in the arena of whispered gossip. And one of the most important of these issues—smoking as a professional practice issue for addictions professionals—is approached primarily through heated debates about organizational smoking policies. The time for more open and far-reaching discussions of ATOD-related decision-making by addictions professionals is long overdue. This article:

1) reviews the history of ATOD use and related problems as a professional practice issue in the addictions field;
2) defines ethical, legal, and clinical issues that arise in response to the ATOD-use decisions of addictions professionals; and
3) offers guidelines for addictions professionals related to ATOD-use decision-making.

The focus of these discussions will be on the ATOD-related decision-making of the individual who works in the field, rather than the broader polices that addiction treatment organizations should adopt related to such use. The guidelines set forth here are humbly and respectfully submitted with full awareness that others of good faith and deep commitment to the addictions field will view some of these issues differently.

A Historical/Personal Retrospective

Early History

The earliest recovery mutual aid societies span eighteenth and nineteenth century Native American "recovery circles," the Washingtonian revival of the 1840s, recovery-focused fraternal temperance societies, the ribbon reform clubs, local recovery societies (e.g., the Drunkard's Club, the United Order of Ex-Boozers), and institutional aftercare groups (Keeley Leagues, Godwin Association) (White, 1998). Members of these organizations reinforced their own commitment to sobriety by performing rescue work with other alcoholics and by serving as temperance speakers and organizers. In these societies, personal recovery was viewed as an essential credential for reaching out to others who were addicted.

> *For the reformed inebriate knows each avenue to his brother's heart; he highly touches the string on which hangs all his sorrow; no rebuke mingles with his invitation of welcome...* (Woodman, 1843, p. 95).

Two problems arose within this early history. The competition between reformed men making public temperance speeches led to exaggerations and outright fabrications. Exposure of such mistruths, in a process remarkably similar to the recent controversies surrounding James Frey's *A Million Little Pieces*, discredited the larger recovery movement of that period (White, 1998). A second problem was the relapse of reformed men who had become well known temperance lecturers/missionaries (White, 2000a). Men like Edward Uniac and Luther Benson, who tried to find sobriety on the temperance lecture circuit, suffered highly publicized relapses. Uniac died of an overdose of whiskey, bromides, and opium while on a temperance lecture tour in Massachusetts, and Benson drank his way into the Indiana Asylum for the Insane (Benson, 1896; Berry, 1871). Like many of his peers, Benson had thought that throwing himself into temperance work would quell his own appetite for alcohol.

> *I learned too late that this was the very worst thing I could have done. I was all the time expending the very strength I so much needed for the restoration of my shattered system* (Benson, 1896, p. 128-129).

Even John Gough, the most successful of all the nineteenth-century recovery missionaries, experienced several early relapses after beginning work as a temperance speaker (Gough, 1870). The public downfall of some of these early leaders reinforced the ways in which seemingly private behavior could discredit sobriety-based social movements.

The American Temperance Movement exerted an enormous influence on the rise of addiction treatment in the United States. The therapeutic branch of that movement performed rescue work with drunkards and advocated the creation of special institutions for the moral and medical care of the drunkard. All of its members had signed a personal pledge of abstinence before embarking on their rescue work. That influence also shaped the expectation that those working in early inebriate homes and asylums, addiction cure institutes, rescue missions, and inebriate colonies would model the sobriety they were helping others achieve (White, 1998).

In such an abstinent environment, even a past history of addiction could call into question one's ability to work in treatment institutions. A debate raged between the branches of the field on this question, with inebriate homes and some addiction cure institute leaders advocating that personal reform constituted a valuable credential in providing moral uplift for the drunkard, while leaders of the more medically oriented inebriate homes and asylums suggested that past addiction disqualified one for such work. Dr. T.D. Crothers argued this latter position with great passion in editorials that appeared in the *Journal of Inebriety* in the closing years of the nineteenth century.

> *It is confidently stated that a personal experience as an inebriate gives a special knowledge and fitness for the study and treatment of this malady. While a large number of inebriates who have been restored engage in the work of curing others suffering from the same trouble, no one ever succeeds for any length of time or attains eminence…Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic defects of the higher mentality…The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the work for any length of time* (Crothers, 1897, p. 79).

While there is evidence that some early addiction treatment practitioners suffered relapses resulting in death or disengagement from the profession (White, 2000c), these events appear to be the exception to otherwise significant contributions by recovering people working as physicians and managers within early inebriate treatment institutions.

The Middle Years

The debate over the question of alcohol and drug use by the addictions professional died in the early twentieth century in the larger collapse of addiction treatment as a professional field. As the larger field faded into obscurity, local experiments in addiction treatment continued, the most significant of which were the lay therapy movement started in Boston and the brief spread of morphine maintenance clinics. The roots of the lay therapy movement can be traced to Boston, where the leaders of the Emmanuel Episcopal Church established a clinic to treat nervous and mental disorders via the integration of religion, psychology, and medicine.

Rapidly developing a specialty in the treatment of alcoholism, the Emmanuel Clinic developed techniques to treat alcoholics and to then recruit and train some of those treated as lay alcoholism psychotherapists. Individuals such as Courtenay Baylor, Francis Chambers, Samuel Crocker, James Bellamy, William Wister, and Richard Peabody were treated within this lay therapy tradition and went on to long, often distinguished careers as lay therapists (White, 2000b).

The continued abstinence of the lay therapists was a cornerstone of their work, as disclosure of their own recovery stories and recovery maintenance strategies was central to their approach to alcoholism therapy. The precise support mechanisms used by these lay therapists to sustain their recoveries is unclear. There was a support structure available (the Jacoby Club), but there is no evidence that the lay therapists participated in the Club. Problems of relapse among some of the lay therapists (Wister, Crocker, McKay, and Peabody) raised questions about the potential to replicate lay therapy broadly across the country (McCarthy, 1984), but this role was sustained through the 1940s, 1950s, and 1960s (by such noted lay therapists as James Lamb Free) and constitutes an important precursor to modern addiction counseling (Anderson, 1944; White, 1998).

Very little is known about those working in the morphine maintenance clinics that briefly flourished between 1919 and 1924, although there is evidence that Dr. Charles Terry, one of the pioneers of the morphine maintenance clinics, developed severe alcohol-related problems later in his career (Courtwright, 1986). Terry's experience illustrates one of the anomalies of the addictions field: the vulnerability of those who work in the field to develop ATOD-related disorders. Whether this is a result of the attraction of those with increased vulnerabilities to the field, or of some contagious element activated by sustained exposure to the field, remains a question of some speculation. What is clear is that the ATOD-related impairment of service professionals within the field has long served as a stain on the field's professional and cultural credibility (White, 1998).

Multiple service roles followed the founding of Alcoholics Anonymous (AA) in 1935. Sponsorship evolved within AA in the early 1940s, and AA members who were physicians and nurses worked within newly opening "AA Wards," "AA Farms," and "AA Retreats" (Anonymous, 1952). Such roles became more formalized in the emergence of the Minnesota Model in the late 1940s, with the State of Minnesota establishing a "counselor on alcoholism" civil service title in 1954. The spread of this model and the continued lay therapist role within new experiments with outpatient alcoholism clinics set the stage for the emergence of the modern alcoholism counselor role (White, 2000b).

This emergence was marked by considerable debate over the question, "Who is qualified to treat the alcoholic?" What became known as the "Krystal-Moore debate" characterized the poles of this controversy. Dr. Henry Krystal argued that only the psychoanalytically trained psychiatrist was equipped to treat the alcoholic and that the lack of such training rendered one ineffective and potentially dangerous. Dr. Robert Moore took the opposing position that individual psychotherapy was not the treatment of choice for alcoholics, and that lay counselors, if supervised by professional psychotherapists, could provide effective support for recovery initiation (Krystal & Moore, 1963). One of the wise leaders of the modern treatment field characterized this prolonged debate as "noisy emotional outbursts launched from shaky premises on both sides" (Ottenberg, 1977, p. 56). Significant for our current discussion is the fact that neither Krystal nor Moore identified past addiction or present abstinence as a critical qualification for those treating people addicted to alcohol (McGoldrick, 1964).

The rationale for the training of those in recovery to serve as alcoholism counselors was that they could offer living proof of the transformative power of recovery, serve as a role models of sobriety-based problem-solving, establish empathy and communication with alcoholics who bristled at professional authority, and help orient clients to the program of Alcoholics Anonymous (Blume, 1977). It was through these roles that personal abstinence and recovery served as a credential in the gestation and birth of alcoholism counseling as a profession. At the same time, it created early ambiguity and conflict related to the delineation of the roles of A.A. sponsor and lay therapist (counselor).

Modern History

My own personal/professional history reveals the evolving ambiguities and contradictions related to ATOD use by addictions professionals in the modern era. I entered the addictions field at a time it was really two fields: an alcoholism field and a drug abuse field. I worked with a foot in each of these fields as a self-identified "ex-addict" whose beliefs were shaped most heavily under the tutelage of Gateway House, an early therapeutic community (TC). At Gateway, like most of the TCs of this period, drinking was accepted and even promoted to clients via earned drinking privileges, and occasional social drinking was the norm among TC staff. Alcohol was simply not seen as a "drug." The growing prevalence of alcohol problems among "ex-addict" staff slowly altered that perceptual blindness.

A symbolic event marked the field's need to end its segregation between alcohol and drug camps. In 1978, Charles Dederich, the founder of Synanon— the first ex-addict-directed therapeutic community (Janzen, 2001)—was arrested. The scene of Dederich being carried in a state of extreme drunkenness into police custody (for charges of conspiracy to commit murder) constituted vivid testimony of the flawed dichotomization between alcoholism and addiction treatment and recovery. Dederich's plummet from power offered powerful testimony that professional pioneers, through their own personal decisions and behaviors, could wound the very fields they had earlier nurtured into existence.

Persons recovering from alcoholism were the mainstream workforce of the alcoholism programs of the 1960s and 1970s that were spawned by funds from the Office of Economic Opportunity (OEO), the National Institute on Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). These programs grew explosively in the early 1970s at a time when few guidelines existed on how to recruit, select, orient, train, and supervise recovering people, who were then branded as "paraprofessionals." Fueled by a growing body of knowledge suggesting the potential effectiveness of peer-facilitated models of change (Riessman, 1965; Durlak, 1979; Hattie, Sharpley & Rogers, 1984), particularly within the arena of addiction recovery (Brown & Thompson, 1976; Longwell, Miller, & Nichols, 1978; Connett, 1980)[1], recovering people with little sobriety time were thrust into positions characterized by low pay, poor role definition, and excessive demands for time and emotional energy.

Concerns about the relapse of counselors grew as this "new profession" came of age (White, 1979; Kinney, 1983; Wilson, 1984). That many recovering people went on to become leaders within this field under such circumstances is testimony to the transformative power of recovery that masks the casualties of many of their peers. The growing consciousness of such casualties led to the expectation that those first certified to work in the field would have "no history of alcohol or drug misuse for a minimum of two years immediately prior to certification" (From the 1974 Littlejohn Report, Quoted in Blume, 1977, p. 563). Recovering people working as alcoholism counselors were expected to have two-to-five years of stable sobriety and sustain their sobriety through "working the program"—active involvement in A.A. or Al-Anon (McInerney, 1973).[2]

With the rapid diffusion of methadone maintenance treatment (MMT) in the late 1960s and early 1970s, methadone-maintained counselors were caught in a purgatory of conflicting messages. Clinic doctors defined methadone as a life-saving medicine, while professional critics, social activists, friends, family members, and former-addict peers often characterized methadone as a "technological fix," a substitute high ("poor man's heroin"), a genocidal poison, or a confession of street incompetence (e.g., "methadone is for losers"). The low-dose policies and scarcity of recovery support services in MMT clinics of this era generated high relapse rates and high rates of secondary drug use. Alcohol problems and relapse to opiate addiction were common occurrences—among clients and staff. The highly stigmatized status of methadone left the lives of many methadone clients and methadone-maintained staff hiding their "dirty little

[1] Such studies have continued. See Aiken, LoSciuto, Ausetts, & Brown, 1984; Blum and Roman, 1985; Galanter, Castaneda & Salamon, 1987; McGovern & Armstrong, 1987; Stoffelmayr, Mavis & Kasim, 1998)

[2] Sobriety requirements changed during this early history, with the early OEO alcoholism programs of the 1960s requiring only one year of sobriety for their counselors.

secret"—a status that remained in the decades that followed, in spite of overwhelming scientific evidence of the effectiveness of MMT (Murphy & Irwin, 1992).

The polydrug counterculture of the 1960s generated its own brand of folk healers and service workers via the emergence of crisis and drop-in centers (including "acid rescue"), free clinics, rock festival medicine, drug-testing services, outreach ("streetwork") programs, outpatient counseling clinics, and "crash pads." Drug use by those working in these institutions was seen more as a badge of cultural membership than a breach of ethics, although there was an emerging etiquette about not "holding" while you were at the service facility and not being "stoned" or "tripping" during your shift. The line between service provider and service recipient was a fluid one in this world, with many individuals cycling in and out of both roles. A core of these early workers matured out of such use; migrated into structured programs of recovery; or attempted, not always successfully, to continue drug use (e.g., smoking marijuana) in secret.

As money flowed into the field in the 1970s and 1980s and the field became a less stigmatized professional arena, growing numbers of psychiatrists, psychologists, social workers, and business entrepreneurs arrived. Some were drawn to the field's frontier status. Others were drawn to the field to work out their own problematic relationships with alcohol and drugs or to sort out having survived families with such problems. Consciousness of, and contradictions related to, such problems were magnified when addiction services were integrated into the traditionally heavy drinking cultures of mental health and criminal justice institutions in the 1960s and 1970s.

The diverse populations that made up the addictions workforce in the 1970s did share one thing in common: daily rituals of massive nicotine and caffeine consumption. The full spectrum of ATOD use was most evident at the field's early state and national conferences. In the evenings at such conferences, workers in recovery clustered within Twelve Step meetings filled with tobacco smoke and caffeine-fueled exchanges of experience, strength, and hope. Outside those meetings, heavy drinking was the norm, and the pungent smell of marijuana in the hallways of conference hotels was common.

That abstinence-based treatment philosophies emerged from such polypharmacy is itself an irony of history, created in good part by the influence these early groups exerted on one another. The growing integration of alcoholism and drug abuse programs within what was then called "combined treatment," and the eventual larger integration of the two fields into one[3], brought new ethics and etiquette surrounding alcohol and other drug use. There were several factors that contributed to this process, including the alcohol problems of ex-addict staff; the "pill" problems of some counselors in alcoholism recovery, the recognition of multiple drug use by a growing number of clients; the growing linkages between treatment programs, Alcoholics Anonymous, and Narcotics Anonymous; and the rapid professionalization of the role of addiction counselor.

As "recovery" took on a broader definition, many workers in the field shed "secondary drugs" or carefully limited their exposure to such substances. After seeing some of my ex-addict peers develop severe alcoholism, reviewing my multigenerational family history of alcohol/drug problems, and assessing my own relationship with alcohol, I joined many in the field who stopped drinking by choice or necessity long after we had defined ourselves as people "in recovery." By the mid-1980s, the field had sobered itself under the influence of the "recovery movement" and a larger sobering of America that some christened the "new temperance movement." The exception to this chemical shedding was the continuation of widespread nicotine and caffeine dependence among addictions professionals. Such dependence remained invisible as a professional and ethical issue, but this was about to change as well.

The addictions field reached a "tipping point" in the late 1980s and 1990s on the issue of nicotine, and excessive caffeine use moved into visibility as a personal and professional issue (Knapp, Rosheim, et al., 1993). It was during this decade that the addictions field and the larger culture began the painful process of redefining its perception of and relationship with tobacco. I stopped smoking in 1988 and shortly afterward terminated the last of my excessive chemical relationships (caffeine). The decision to quit smoking was prompted by individuals who confronted me about the incongruity between my role as a visible trainer in the addictions field and the behavior that I was modeling both to my professional peers and to consumers of addiction treatment services. I reached a point of consciousness that I simply could not continue in this field while in a state of active addiction. In the years that followed, controversies raged (and continue) over program smoking policies for clients and staff. The result was that a growing number of workers in the field, many of whom had for years touted their sobriety and clean time while chain-smoking cigarettes, began severing their relationships with this most lethal of drugs. Collectively, it was like blinders had been peeled off our eyes as we asked ourselves how we had for so long refused to define

[3] The most intense period of this conceptual and organizational integration spanned the years 1975-1985.

nicotine as an addictive drug. It will take another decade for the attitudinal shift about nicotine to reach full fruition, but the die has been cast and is now irretrievable.

As the field began the process of painfully shedding its addiction to nicotine, it became a wetter field through an evolution in its workforce composition. The progressive escalation of educational credentials flowing from counselor certification and licensing standards reached a crescendo in the 1990s, pushing many recovering people out of the field and bringing many allied professionals into the field. This brought a higher proportion of people into the field who were alcohol users and a new generation of young people who were emerging from the binge drinking and new polydrug experimentation of the 1990s.

An interesting change in status occurred during the 1980s and 1990s for those working in the field with recovery backgrounds. Personal or family recovery experiences became a less desirable credential in the rush toward professionalization. The percentage of people working in the field in recovery declined, and those who brought such backgrounds referenced this status less frequently. There was in this move toward professionalization an implicit assumption that those working in the lay therapy tradition without formal, advanced academic credentials were somehow less effective in their clinical work with clients, but there was little evidence to support this assumption.

Studies comparing recovering and non-recovering addiction counselors concluded that recovering counselors are more likely to be older, to be male, to be less educated, to value recovery experience more than education, to feel more positively about their jobs, are to use a broader menu of treatment goals and techniques (McGovern and Armstrong, 1987; Blum & Roman, 1985; Stoffelmayr, Mavis & Kasim, 1998; Stoffelmayr, Mavis, Sherry & Chiu, 1999), but that they do not differ on critical performance measures. For example, no differences between recovering and non-recovering counselors were found related to such measures as client affiliation rates or post-treatment recovery/relapse rates (Machell, 1991; Brown & Thompson, 1976; Longwell, Miller & Nichols, 1978; Connett, 1980). A single study evaluating client perceptions of counselor backgrounds found that clients viewed those with more professional training as more trustworthy and expert regardless of recovery background (LoBello, 1984), and another found that clients of professionally educated counselors were more likely to be enrolled in educational programs following treatment than clients of recovering counselors who lacked professional education (Aiken, LoSciuto, Ausetts & Brown, 1984). One could read in the current proliferation of non-clinical recovery support roles (e.g., outreach workers, recovery coaches, personal recovery assistants, recovery support specialists) a backlash against the over-professionalization of the role of addiction counselor (White, 2004a). This latest shift is bringing a new generation of recovering people into service roles in addiction treatment and grassroots recovery advocacy agencies.

It is obvious from this brief summary that my motivations for writing this article are numerous: grief over the ATOD-related loss of professional peers, unabashed survival guilt, a desire to help a new generation of addictions professionals, and hope that I might contribute something of value to the ethics and etiquette of this most unusual and rewarding profession. Perhaps more than anything, I am weary of helping clients and colleagues celebrate their recoveries from addiction to alcohol, opiates, and stimulants, only to watch them later die premature deaths due to the consequences of nicotine addiction. I am also concerned about the addictions field's tenuous, probationary status within this culture and believe that anything that hurts the image of the treatment field—including ATOD-related incidents of its practitioners—contributes to the potential revocation of our legitimacy as a cultural institution.

As a field, we have entered the twenty-first century with the most diverse workforce in our history—a diversity that is again raising questions about what appropriate stance addictions professionals should take regarding their own ATOD-use decisions. For the foreseeable future, that decision-making will continue to take place within an evolving history filled with many contradictions and ironies. If one looked at this field from the outside in, a number of such contradictions would be puzzling.

- We are a field that historically has defined abstinence from certain drugs (e.g., alcohol, heroin) and dependence on other drugs (e.g., nicotine, caffeine) as criteria for in-group occupational status.
- Service professionals with AOD problems who are not self-identified as being "in recovery" face no length-of-sobriety requirements and may be hired and work without notice in the field until those problems affect their performance.
- Persons who self-identify as being in recovery face length-of-sobriety requirements not applied to other staff.

- Professionally credentialed counselors in recovery who withhold that recovery status may work in the field with less than minimum sobriety requirements, but could not do so if they were honest about their lengths of sobriety.
- People who experience and are treated for other health problems (including other behavioral health problems) may continue working in the addictions field as long as their problems do not affect their performance. Following treatment of other problems, they are allowed to return to work as soon as their physicians release them, but they may not do so following treatment of AOD problems.
- Addiction treatment programs promote employee assistance programs that recommend treatment as an alternative to terminating AOD-impaired employees, yet do just the opposite with their own employees.
- There are programs that prohibit counselors from disclosing whether they are in recovery or not, yet demand to know the recovery status of each job applicant for a counseling position.
- There are programs that require evidence of pre- and post-hire participation in a particular pathway of recovery (e.g., Twelve Step meetings for those in recovery), but do not expect such participation for non-recovering staff.

As this discussion proceeds, we will try to explore the basis for such contradictions and the best ways of charting our path through this ill-marked and sometimes hazardous territory.

Defining Nexus: Rights to Privacy vs. Professional Duties and Obligations

Most addictions professionals would agree that there are spheres of their lives that are outside the arena of appropriate scrutiny by their employers and their professional organizations. Most would also agree that work in the addictions field brings duties and obligations that transcend the workplace and one's working hours. The troublesome question, therefore, is, "Where does one draw the line between rights to privacy and professional duties and obligations?" There is a substantial body of legal and ethical literature suggesting that an individual's private behavior is precisely that until there is a nexus—an inextricable connection—between private behavior and one's professional performance (White and Popovits, 2001).

Ethically speaking, the ATOD use of addictions professionals during non-work hours is not subject to professional scrutiny until that behavior harms their ability to perform professionally or otherwise inflicts harm to other persons or institutions. LeClair Bissell and James Royce, authors of the first ethics text for addiction counselors, argued that there was a clear nexus on the issue of personal alcohol/drug use.

> *If there are complaints that private life is just that and not the concern of the employer or colleague, it is quite fair to reply that, in this particular field, the use of chemicals and one's belief system about them is job related* (Bissell & Royce, 1987, p. 10).

Before exploring specific case studies of ATOD-related professional practice issues, we will try to shed more light on this concept of nexus. Personal ATOD decisions are best filtered through some of the core values that have historically guided helping professionals (White & Popovits, 2001).

- The value of **obedience** dictates that addictions professionals adhere to the promises made to comply with laws and regulations governing their employment and their profession, e.g., compliance with ATOD use-related standards in personnel policies and professional codes of ethics linked to certification or licensure.
- The value of **competence** demands that addictions professionals not do anything that would compromise their professional decisions and behaviors, e.g., performing professionally while under the influence of alcohol.
- The value of **honesty** makes it incumbent upon addictions professionals to accurately represent statements they choose to make related to their ATOD use history and their recovery history and status.
- The values of **fidelity** and **loyalty** demand that addictions professionals maintain their fiduciary obligation to serve the needs of their clients and protect the integrity of their service organizations and the addictions field.

- The value of **non-malfeasance** is a call to refrain from hurting anyone through the performance of one's professional role, e.g., injury of a client due to one's personal impairment.
- The value of **self-interest** recognizes the need for service professionals to protect themselves, both in terms of their physical/psychological safety and in terms of their professional reputation.

All of these core ethical values have potential relevance to situations involving ATOD-related decisions on the part of addictions professionals.

Another way to approach ATOD-related decisions is to ask oneself who stands to benefit and who could be injured by a particular ATOD-related decision. ATOD decisions constitute an arena of *multi-party vulnerability*. That means that multiple parties—the addictions professional, past/present/potential service consumers, the service organization, the larger professional field, and the community—could be injured by the addictions professional's ATOD-related decisions.

ATOD-related Professional Incidents

With this background laid, we will further explore how this nexus occurs between our private and professional lives. We will do this through brief vignettes drawn from the author's consultations on ethical issues that have arisen within treatment organizations around the country.[4]

1. **Substance-related Impairment of Performance During Scheduled Work Hours:** Raymond had worked as a counselor for two years within the addictions field prior to the day he arrived at work under the influence of alcohol. The resulting suspension and intervention led to his admission to alcoholism treatment and his subsequent decision to work outside the addictions field during his early recovery. Raymond's behavior illustrates one of the most direct ways in which one's personal relationship with alcohol or drugs, in this case a troubled relationship, can ripple into the arena of professional performance. Other cases involve less obvious effects on performance, e.g., missed work, feigned sickness due to hangovers or withdrawal, anxiety and depression, deterioration of clinical effectiveness.
2. **Substance-related Impaired Performance While "On Call":** Marybeth responded to an emergency call from a local hospital and felt that she had handled the situation just fine until the client's spouse filed a complaint that Marybeth was "reeking of booze" when she arrived at the hospital emergency room to conduct the interview. Marybeth's response was that she had consumed a beer with her dinner but suffered no impairment of any kind. The distinction between "use" and "impairment" are sometimes indefinable in such situations. Mary's behavior injured her own reputation and that of her agency. She was disciplined for violation of the agency policy related to consumption of alcohol while carrying a pager.
3. **Substance-related Deterioration in Self-care Responsibilities that Affect Professional Performance:** Fred tried to compensate for his increased drinking away from work by spending more hours at work as an intake worker at a treatment agency. The combination of increased alcohol intake, excessive work, and decreased sleep took its toll on his health and his performance. Ironically, the earliest sign of later troubles in this case was an increase in perceived productivity. A year later, everyone knew something was going on with Fred, but no one was sure what.
4. **Allegations of Substance Impairment:** After a sustained cold, Cathy received a prescription from her physician. Over the next two days at her job as an addictions counselor, Cathy became quite disoriented, giddy, and light-headed, and was forced to go home early on the second day. Several of the clients in treatment were whispering that Cathy was stoned. In another example, when Barry's clinical supervisor confronted him about what appeared to be substance intoxication, he acknowledged that he was taking a prescription for anxiety. Further investigation revealed that Barry had taken three times the prescribed dose.
5. **Substance-influenced Breaches in Relationships with Clients:** Lionel, an addictions counselor, resigned amidst allegations of financial and sexual exploitation of clients. A close review of his caseload revealed other simultaneous cases of clinical abandonment (service disengagement,

[4] All names in these incidents have been altered.

fabrication of clinical contacts). Upon further investigation, it appeared that these behaviors followed on the heels of Lionel's relapse to cocaine addiction.

6. **Positive Random Drug Test:** Many addiction treatment agencies or units are governed by drug-free workplace policies that call for random drug testing. Robert had been viewed as an exemplary employee until he tested positive for cocaine on a random drug test. When another employee, Shandra, was called to take a random drug test, she reported that she had taken a prescription narcotic, tested positive for the drug she reported consuming, but could not produce a prescription for the drug, as her husband had given her one of his pills after she had strained her back—a technical case of illegal drug use.
7. **Contraband:** An even more direct violation of drug-free workplace policies involves bringing alcohol or other drugs and related contraband into the addiction treatment workplace. Thea's alcohol problem remained hidden until a secretary sent to retrieve a file found a bottle of bourbon in the back of a drawer in Thea's desk—a significant breach of agency policies prohibiting bringing contraband into the workplace.
8. **Substance Use/Misuse in the Community while Acting in One's Professional Role:** Brady was assigned to do a speaking engagement at a local service club, in which he provided an overview of his agency's addiction treatment services. The following day, the director received a call in which he learned that Brady had liberally availed himself of the open bar before he was due to speak, and that his words were slurred during his speech. This complaint reflects ways in which ATOD-related behavior in the limbo between personal and professional time can be problematic for workers and treatment organizations. The most frequent issues that arise in this area are related to behavior at professional meetings or conferences.
9. **Substance Use/Misuse in the Community on One's Own Time:** Mary is a 22-year-old recent college graduate who works in an adolescent addiction treatment program. As her supervisor, you have received several complaints that Mary has been seen drinking heavily at some of the most notorious "party bars" in your community. It has also come to your attention that Orville, a preventionist who has major responsibility for providing anti-tobacco education in the local schools, is smoking in public. Are these private behaviors or professional practice issues? These examples illustrate how the off-work behavior of individuals working in the addiction field can raise professional practice issues that affect the reputations of service workers, service organizations, and the larger field. Many addiction treatment organizations have codes of professional practice that explicitly define expectations in this area.
10. **Arrest/Conviction on a Substance-related Violation:** Andrew, an addictions counselor, was arrested in an undercover sting for solicitation of prostitution, and was charged with possession of marijuana at the time of his highly publicized arrest.
11. **Loss of Work Credentials:** Marty, a member of the maintenance staff at an addiction treatment organization whose duties involved driving, lost his driver's license due to a driving while under the influence conviction following his arrest during non-work hours. Beatrice, a nurse working in a detox unit, lost her nursing license following her conviction for forging prescriptions for narcotic drugs.
12. **Relapse of Person for Whom Recovery Status is Linked to Job Performance:** Felicia works as a recovery coach in a local addictions treatment program. The supervisor received a report from another staff person that Felicia was observed drinking over the weekend at a concert in a neighboring community. Felicia represents herself as having been in continuous recovery for the past three years. There are several issues here, including the potential effects of Felicia's apparent relapse on her own health and career and the effects that Felicia's behavior/status could have on her clients and on the organization. Multiple professional practice issues are evident in this vignette, including the issue of misrepresentation of credentials within a role in which stable recovery is a core credential.

    In another example, Jeremy self-identified as a person in recovery when he was hired as an addictions counselor and has represented himself as being in recovery for eight years. When questioned about being seen consuming alcohol, Jeremy responds that alcohol was not the drug to which he was addicted, that he has no problem with alcohol, and that his recovery status is based on his last date of heroin use. The situation with Jeremy raises questions about secondary drug use for people in recovery and forces a deeper exploration of the very definition of recovery. There are no

universally accepted standards regarding what drugs are embraced within the definition of recovery, what constitutes a relapse, and when one is ethically bound to report ATOD use or related problems to one's supervisor.

13. **Dual Relationships:** A final example of nexus arises when relationships linked to one's past AOD use resurface in the treatment setting. Theresa, an addictions counselor, admitted to her supervisor a year ago that she had developed an addiction to cocaine. After taking a leave of absence to go through treatment, she returned in a non-service role and has recently returned to a counseling role. Today she recognizes among clients being admitted to treatment a person from whom she purchased cocaine several times.

These vignettes illustrate the wide variety of ways in which one's ATOD-related decisions can ripple into the arena of professional practice. Before offering guidelines relevant to these situations, we will explore ways in which personal ATOD decisions of addictions professionals can influence service relationships and the service process.

ATOD Use, Transference, and Countertransference

Transference is a term used to describe ways in which a client's experiences (feelings, perceptions, expectations, behavioral patterns) in his or her most significant prior relationships are projected into his or her relationship with the addictions professional. *Countertransference* is the term used to describe the total emotional reaction of the addictions professional to each client—responses that can involve projections from the therapist's own past relationships, the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983). Countertransference is composed of both collective sentiments (those based on categorical responses to such issues as race, gender, age, sexual orientation, type of AOD use) and idiosyncratic sentiments (those based on unique emotional reactions of the counselor to a particular client). In psychoanalytic thinking, the manner and degree to which these transferences and countertransferences are actively managed exert a profound influence on the outcome, good or bad, of the helping process. The addictions professional's own ATOD-related attitudes and behaviors elicit transference responses from clients, and each client's unique ATOD-related behaviors and lifestyle elicit feelings from the addictions professional that can help or hinder the helping process.[5] In this section, we will explore how one's own ATOD-related history and current ATOD use decisions can influence one's service relationships.

In 1963, Dr. Henry Krystal suggested an important proposition:

> *Since the therapist is his own working tool, he must be freed from blind spots and inhibitions. Only in this way can he make constructive use of his countertransferences, rather than have them disturb the treatment, or his own life, or both* (Krystal & Moore, 1963, p. 711).

Knowledge of addiction and recovery is a critical competency of addiction counselors. Such knowledge and its effective use have not been found to be contingent upon recovery status, and the effects of the counselor's past or present ATOD use have not been a subject of focused study in the field. Historically, we have focused on recovery status and length of sobriety for individuals seeking to work in the field because of the close nexus between this status and the mission of the field, but the broader spectrum of ATOD use status has not been a visible issue.

There are many things that combine with ATOD use patterns to affect counselors' credibility and their service relationships. Differences in credibility and effectiveness, for example, could be compared across several subgroups of clinicians, including:

- Persons in recovery with educational preparation,
- Persons in recovery without educational preparation,
- Persons with no personal recovery experience, but with addiction and recovery experience within their families,

[5] One's ATOD history and decisions can also influence the clinical supervision relationship (See Culbreth and Borders, 1998).

- Persons with no personal recovery experience, with addiction experience in their families, but with no recovery experiences in their families,
- Persons with no personal recovery experience with educational preparation,
- Persons with no personal recovery experience and no educational preparation, and
- Persons with no personal recovery experience, but who are developing or are now experiencing AOD-related problems.

The closest we have come as a field to identifying such subgroupings is a Michigan study (Stoffelmayr, Mavis, & Kasim, 1998) that surveyed 634 staff members of 51 treatment programs and found that 44% of respondents identified themselves as non-recovering, 30% as recovering, and 26% as not recovering but part of a family that had experienced addiction or recovery.

The effect of past or current ATOD use on clinical effectiveness remains a question ripe for theoretical speculation and scientific study. As a close observer of this issue for nearly four decades, I would offer the following observations about how our past or current ATOD use experiences can enter into our service relationships.

A counselor's history of living in environments without ATOD-related problems and the ability to control his or her own ATOD relationships may convey either incomprehensibility (at best) or an air of superiority and condescension (at worst) to clients who lack volitional control over such relationships. The potential of such attitudes to disrupt treatment led Howard and Hurdum to make the following declaration in 1940:

> *It is essential that complete abstinence be advised to the patient. Accordingly it is advisable that the therapist himself abstain, lest his acts or attitude seem to imply "you must not drink, but it is all right for me to do so as I am a superior person"* (Howard & Hurdum, 1940, p. 357).

Not everyone would agree with this admonition, but the observation of Howard and Hurdum underscores subtle ways in which the therapist who has no history of ATOD problems can inadvertently express contempt toward those who do. One factor that historically distinguishes addictions professionals from other service professionals who interact with those with severe AOD problems is a service relationship based on moral equality and emotional authenticity (White, 2004b). But as we shall see, recovery alone does not ensure such a relationship, nor does lack of recovery status prevent one from developing such a relationship.

Counselors with past and current moderate ATOD relationships may also tend to expect or try to cultivate in their clients the same type of rational control over ATOD consumption that has worked successfully in the counselor's life. There is nothing in the normal user's experience that will provide an understanding of the addicted client's loss of volitional control over the timing, location, quantity, and consequences of ATOD use.

> *Jerome was hospitalized via the emergency room for unbearable pain (self-described as "a knife being pulled across my abdomen") related to acute alcoholic pancreatitis. He was heavily medicated with narcotics for more than two weeks before his condition stabilized enough to consider discharge. Each day of his stay, his physician and nurses communicated to him that this intense pain would return every time he drank. Upon his discharge, Jerome went to his car, reached for the bottle under his seat, and began drinking. He was readmitted before he ever left the hospital grounds.*

For those who haven't experienced addiction close up, such behavior can be completely inexplicable and result in frustration and anger at the client's continued self-destruction, the therapist's emotional disengagement from the service relationship, and "therapeutic discharge" of the client for what appears to be willful recalcitrance.

Those workers with developing or unacknowledged ATOD problems may tend to underestimate the severity of ATOD problems in others as a way of minimizing their own emerging problems or try to work out these emerging problems via their clinical work with clients (McInerney, 1973). This underscores the need for service professionals who use psychoactive drugs of any kind to make regular effort to evaluate the effects of such use on their own lives and on their professional work with others. The goal in suggesting this is not a masked attempt to sober up the entire addictions treatment workforce. It is intended to prevent the spillover of personal ATOD issues into the addictions professional's service relationships. There is little doubt, for example, that the widespread addiction of the treatment workforce to

nicotine has dramatically slowed the process of acknowledging and assertively treating nicotine dependence within addiction treatment programs and fueled myths that supported this delay (e.g., the myth that quitting smoking and quitting drinking at the same time increases the risk of relapse).

Counselors (those without and even those with addiction histories) may unconsciously act out social and professional stigma linked to addiction, making assumptions based on misguided stereotypes and conveying feelings of contempt toward persons with certain drug choices and addiction-related lifestyles. Such contempt can arise from the social values one has learned as a member of this culture or through one's past experiences with these issues, either personally or in one's own family and social network. Counselors in recovery may respond to the internalized stigma associated with their addiction/recovery status through competition and conflict with other professionals, overcompensation (excessive hours), over-identification with clients, estrangement from their own recovery support groups, and relapse (Blume, 1977).

As noted earlier, those without ATOD histories who become addictions professionals can bring attitudes and subtle behaviors that signal an air of moral superiority to clients. The same can occur among those with addiction backgrounds. It is important to remind oneself of the strange pecking order within cultures of addiction through which members of each group elevate themselves by castigating those in other groups. Historically, "alkies" and "junkies" held each other in mutual contempt, and even the classic junkie world had a status order ranging from the "gutter hype" to the "righteous dope fiend." The point to be made here is that the prior positions one held and the attitudes endemic to those positions can be inadvertently brought into one's later career as a counselor.

Counselors in personal recovery from severe drug dependence can be particularly prone early in their counseling careers to see all AOD problems through the addiction lens. In this case, their abstinence becomes a distorting lens that sees all use as addiction and any failure to admit an ATOD problem as the "disease of denial." Some recovering counselors may also be prone to program the recoveries of those with whom they are working through the counselor's own narrow band of recovery experience.

This is a good time in our discussion to reaffirm the obvious: recovery status or abstinence by itself is not an addiction counseling credential—an insight recognized very early in the modern history of addiction counseling.

> *The former problem drinker, however, who controls his drinking on the basis of his A.A. activities, but who has not discovered and effectively worked through his own emotional problems, is in a worse position to function as an individual therapist to the alcoholic than a person without a history of alcoholism in the past but with no experience* (Krystal & Moore, 1963, p. 710).
>
> *A person who after some years of sobriety still attends AA seven nights a week has not yet learned to play, relates poorly to the opposite sex and to family, and has little interest in anything other than alcoholism. Such a person is scarcely an ideal candidate [for the role of alcoholism counselor]* (Bissell, 1982, p. 811).

I would add to Krystal and Bissell's observations that, even for the most fully actualized person in recovery, recovery status alone is not a sufficient foundation for addiction counseling.

All ATOD-related decisions and experiences constitute potential sources of bias. For example, where counselors in short-term recovery are prone to work out their own immediate recovery issues through their clinical work with clients, I have observed counselors in long-term recovery reaching a point of detachment from their addiction histories, losing their capacity for empathic identification, developing an air of moral superiority, and exhibiting great intolerance of and anger toward the actively addicted. This is analogous to highly successful minority group members who exhibit great contempt for those within their own ethnic group who exemplify racially stereotyped behavior.

There are several ways in which the addictions professional's ATOD use can influence clients, e.g., what the client observes or hears from others about the counselor's ATOD-related behavior, what the counselor tells the client about such behavior, or what the client senses or suspects about such behavior. One of the most obvious ways is through the behavior modeled by the service professional. Clients can share or take on a counselor's current addictive behavior and use the counselor's behavior to justify addictive thinking and behaviors (e.g., "if it's okay for my counselor to smoke, it's okay for me to smoke"). The most direct way in which the counselor's own ATOD history influences the client and others is through the act of self-disclosure of past or current ATOD experiences.

The Ethics and Etiquette of ATOD-related Self-disclosure

There are several rationales for counselor self-disclosure in the addiction treatment arena. Such disclosures can be aimed at lowering resistance, enhancing engagement, diminishing isolation and shame, enhancing hope, and illustrating particular problem-solving strategies. Self-disclosures are less in vogue today as a result of the professionalization of addiction counseling. Volunteering information or responding to questions about one's past or current ATOD experiences is a potentially troublesome area best sorted out within the larger context of the ethics of all self-disclosure in the clinical setting. The most significant issues related to counselor self-disclosure include problems of:

- lost focus, e.g., disclosures that divert the interview from the experience of the client to the experience of the counselor;
- inappropriate timing, e.g., disclosures that slow the development of or abort the therapeutic relationship;
- duration, e.g., disclosures of excessive length that constitute a form of introspective disengagement on the part of the counselor;
- immediacy, e.g., communicating current experiences from the counselor's personal life about which the counselor lacks objectivity and emotional control;
- inappropriate levels of intimacy, e.g., excessively intimate disclosures that diminish a client's feelings of physical and psychological safety in the service relationship or diminish the client's confidence in the abilities of the counselor; and
- cultural violation, e.g., disclosures that violate cultural etiquette.

There are also problems that can arise related to counselor disclosures of past or current ATOD use in professional settings (e.g., as a professional trainer), during presentation to the public, or in interviews with the media. The problems that arise related to trainer self-disclosure are very similar to those noted above that can occur in the counseling relationship, but public and media disclosures can be more complicated. I have had many experiences with the media, some quite positive and others that I thought would be at a PBS level that turned out to be closer to tabloid TV. The problems related to media are numerous and include programs that:

- victimize clients by emotionally exploiting their pain to elevate viewer, listener, or reader ratings;
- undermine personal recovery by asking questions that, if answered, would violate recovery support group membership guidelines (e.g., A.A. Traditions);
- contribute to stigma by focusing on sensational aspects of addiction that inflame fear and prejudice while failing to tell the recovery story fully;
- misrepresent by omission or distortion treatment methods and scientific data on treatment outcomes; and
- misrepresent by omission or distortion the diversity of pathways to recovery.

Participating in such practices undermines rather than elevates the field's service mission. Counselors also need to avoid serving as intermediaries in enticing clients to participate in media exposure primarily intended for purposes of program marketing.

Up in Smoke: Tobacco Addiction and the Addictions Professional

No ATOD-related issue generates more emotion right now than the issue of smoking as a professional practice issue or proposals for changes in organizational smoking policies in addiction treatment institutions. The nexus between personal nicotine addiction and professional performance is so great that smoking for those working in prevention and treatment will likely become a tragic and ironic artifact within the history of the field. The evidence supporting this shift is overwhelming.

The Factual Case Against Tobacco

1. 60 million Americans are addicted to tobacco (McGinnis & Foege, 1999).
2. 446,000 Americans die each year of tobacco-related diseases, compared to 105,000 from alcohol abuse and alcoholism and 39,000 from other addictive drugs (McGinnis & Foege, 1999).
3. Early onset of smoking and heavy smoking are highly correlated with the subsequent development of other substance use and psychiatric disorders (Degenhardt & Hall, 2001).
4. Heavy smokers have more severe substance use disorders than do non-smokers and more moderate smokers (Marks, Hill, et al., 1997; Krejci, Steinberg, et al., 2003).
5. Between 85% and 95% of people admitted to addiction treatment in the United States are dependent upon tobacco—more than triple the national average (Bobo,1992; Abrams et al., 1996; Burling & Ziff, 1988).
6. People with alcohol problems exhibit more severe nicotine addiction than do smokers without alcohol problems (Batel, P., F. Pessione, et al., 1995; Toneatto, Sobell, Sobell, & Kozlowski, 1995), are less likely to stop smoking (Hays, Schroeder, et al., 1999), and, as a result, bear a greater burden of nicotine-related diseases and deaths.
7. Those with more severe nicotine dependencies have poorer outcomes for the treatment of other drug dependencies (Patkar, Vergare, et al., 2003; Hillemacher, Bayerlein, et al., 2006); continued smoking following treatment for other drug dependencies increases the risk of relapse (Sobell, Sobell, & Kozlowski, 1995).
8. In alcoholism treatment programs in which smoking is not addressed, smoking cessation rates are very low (e.g., 3%) following discharge from treatment (Sobell, Sobell, & Agrawal, 2002).
9. Smoking-related diseases are a major cause of death for people who have successfully recovered from alcoholism/other drug dependence. Of those discharged from alcoholism treatment, more will later die from nicotine-related diseases than from alcohol-related diseases (Hurt et al., 1996).
10. The development of nicotine dependence by non-smokers during and following addiction treatment may constitute a harmful side-effect of such treatment as it is currently designed (Friend & Pagano, 2004).
11. Staff perceptions that most people admitted to addiction treatment do not want to stop smoking are challenged by surveys finding that most patients have a desire to stop smoking (Irving, Seidner, et al., 1994; Joseph, Nelson, et al., 2003), including those with co-occurring psychiatric illnesses (Unrod, Cook, et al., 2004).
12. Recovery rates are not compromised (and in fact are enhanced) when nicotine addiction is treated concurrently with other addictions (Bobo, McIlvain, et al., 1998; El-Guebaly, Cathcart, et al., 2002; Joseph, Nichol, et al., 1993; Lemon, Friedmann, et al., 2003; Sees & Clark, 1993).
13. Smoking cessation interventions provided during addiction treatment increase the rates of long-term abstinence from alcohol and illicit drugs by as much as 25% (Stuyt, 1997; Prochaska, Delucchi, et al., 2004).
14. Recovery from alcoholism increases the probability of successful cessation of nicotine addiction (Breslau & Peterson, et al., 1996).
15. No-smoking policies in addiction treatment programs do not decrease admissions or increase discharges against medical advice or administrative discharges (Hurt & Slade, 1990).
16. The scientific evidence overwhelmingly supports encouraging and assisting smoking cessation for individuals in recovery from other addictions (Sees & Clark, 1993; Sussman, 2002).
17. Staff who continue to be addicted to nicotine constitute a major obstacle to the reform of smoking policies in addiction treatment programs and the revamping of clinical philosophies and procedures related to nicotine addiction in such settings (Psychiatric News, August 4, 2000 ; Falkowski, 2003).[6]

[6] I would like to acknowledge the assistance of Jason Schwartz in conducting this literature review.

Moving forward to address nicotine addiction within the larger rubric of addiction treatment is no longer a question of inadequate research; it is a question of honesty and leadership.

Every day, addictions professionals who have been addicted to nicotine are shedding that addiction and embracing a personal manifesto containing one or more of the following propositions.

Nicotine: A Personal Manifesto	
I choose to:	**I refuse to:**
Forever sever my personal relationship with nicotine; it no longer has a place in my life.	Contribute money to or accept money from a predatory industry that has consciously sacrificed the health of the public for corporate profit.
Help hasten the end of the addiction field's enabling of tobacco addiction among our clients and our workers.	Remain silent about the tobacco industry's targeted marketing to women, children, communities of color, and citizens of developing countries.
Model responsible decision-making regarding all psychoactive drugs and encourage my clients and peers to do the same.	Model a behavior (smoking) that could take years from my own life and the lives of those who could be influenced by my example.
Offer assistance to those seeking to recover from nicotine addiction.	Live the hypocrisy of being addicted while working as an addictions professional.

Guidelines for ATOD Decision-making

ATOD use by addictions professionals is an issue with a long history that continues to be marked by complexities, ambiguities, and a lack of professional consensus. It remains an issue that can rapidly explode, injuring professional careers, service consumers, service organizations, and the broader professional arena in which we work. For the past four decades, I have been called upon to offer advice to individuals and organizations regarding these issues. The wisdom drawn from the history of the field and from my experience as an elder in this field is best summarized in the following guidelines. I offer them with a deep appreciation that others may extract different lessons from this history, and that lessons learned from the experiences of one generation may or may not be applicable to the changing contexts of the next.

1. Respect the fishbowl effect that accompanies work in all status- and stigma-laden fields. Remain cognizant of how your behavior in "off hours" influences the ways in whicyou and your organization are perceived within your community, and how such perceptions influence policy makers and current and potential service consumers.
2. As a professional leader, seek not a life of perfection, but a life of reasonable congruence between the field's core values and your daily conduct. Leaders and visible members of social movements involving stigmatized social issues have no rights to privacy, only decisions and behaviors that help or hurt their causes.
3. Filter decisions related to disclosure of your ATOD use history, your recovery status, and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth), discretion (protect your privacy), and, for those in Twelve Step recovery, the tradition of anonymity at the level of press.

4. If you are in recovery, cultivate and sustain mechanisms of recovery maintenance separate from your professional life. Working in service roles within the addictions field is not a viable program of personal recovery and may even undermine defense structures that have previously served to maintain sobriety.
5. Rigorously evaluate your own past or current relationships with ATODs, their role in your decision to work in the addictions field, and the congruence or incongruence between those relationships and your service responsibilities. Filter your ATOD use decisions through those ethical values that have long guided professional service relationships: competence, honesty, fidelity, loyalty, non-malfeasance, and self-interest.
6. Use your personal/family ATOD-related history and your broader life experiences to enhance mutual identification and acceptance in the service relationship, convey hope and encouragement, and model skills essential to recovery self-management. Exemplify as best you can such core recovery values as self-acceptance, honesty, humility, gratitude, forgiveness, tolerance, and service.
7. If you drink alcohol, use discretion related to when, where, and under what circumstances you drink; the amount you drink; and how you conduct yourself while drinking ("the night has a thousand eyes"). If you drink alcohol, drink within the limits of healthy drinking established by the National Institute on Alcohol Abuse and Alcoholism[7], and NEVER, NEVER drive after having consumed ANY alcohol.
8. If you work within an organizational culture that promotes excessive ATOD consumption, cultivate an outside-of-work support system to neutralize the influence of that culture, develop a sobriety-based support network within this setting, and explore relocation to a healthier organizational environment.
9. If you are consuming over-the-counter or prescription drugs with psychoactive effects or side effects, communicate this status to your clinical supervisor and/or a trusted professional peer, with the request that they help monitor your performance for any untoward effects.
10. If you are in recovery and have resumed ATOD use, you have a professional responsibility to immediately report this change in status to your clinical supervisor; evaluate the effect of this changed status on your clinical performance; and seek immediate help to prevent future harm to yourself, your clients, your organization, and the integrity of the field.[8]
11. If you wish to return to the field after having relapsed while working as an addictions professional, your chances are best if you demonstrate your willingness to meet the highest standards of supervision, e.g., your willingness to: 1) re-enter the field on a probationary status, 2) accept any requested limitation of duties, 3) participate in a formal impaired professionals treatment program, 4) provide random urine drops, 5) provide verification of counseling participation, 6) provide verification of participation in recovery mutual aid meetings, and 7) have a professional peer mentor.
12. If you are using illicit drugs, evaluate the potential effects of such use on those to whom you are personally and professionally accountable. If you value such use more than those to whom you are professionally accountable, seek an expert evaluation of your relationship with these substances or seek employment outside the specialty addictions field. Failure to take those actions is a violation of your fiduciary pledge to this field and the needs of its service constituents.
13. Adhere to all current legal, professional, and organizational standards related to ATOD use.
14. Immediately declare to your supervisor any pre-existing relationship with a potential or admitted client (or a client's family member) with whom your past AOD use or related activities could affect the client's feelings of safety and comfort receiving services at your organization.
15. Remain cognizant of how your reasons for using ATOD influence your attitudes toward, relationships with, and biases related to treatment goals and methods for each client. If you abstain from ATOD, remain aware of the ways in which either the reasons for that abstention or your particular pathway and style of recovery might positively and negatively influence your work with clients, professional peers,

[7] The NIAAA standard is for women to drink no more than one drink per day (total of seven drinks per week) and for men to drink no more than two drinks per day (total of fourteen drinks per week) (Dufour, 1999).

[8] This is not an arbitrary standard applied to those in recovery. I have argued elsewhere (White & Popovits, 2001) that any change in one's personal life that could significantly affect one's clinical work should be reported and processed in clinical supervision.

and the community. Use clinical supervision to identify negative transference and countertransference before such feelings are acted out destructively by you or your client.

16. If you are addicted to nicotine and working as an addictions professional, you have a responsibility to initiate and sustain recovery from that addiction, and to keep seeking personal/professional support until that goal is achieved permanently.
17. Disclose your past or present ATOD experiences and decisions with clients only if that disclosure is clinically strategic, brief, appropriate for the developmental stage of the service relationship, and restricted to past material over which you have emotional control.
18. Beware of stigma pimps from the media who exploit stereotypes and fear for their own personal glorification and profit. Take risks with self-disclosure at the level of press only with individuals and programs that have an established track record of professionalism and respect.

The ultimate mandate for addictions professionals is to conduct their personal and professional lives in a manner congruent with the service mission they have chosen. These suggestions are offered, not as the last word on this subject, but as a stimulus to future dialogue on this important professional practice issue.

In closing, I also find it important to note what I have chosen not to address in this essay. The boundaries of the concept of addiction have eroded considerably, both in the addictions field and in the popular culture. At a professional level, an ever-widening range of excessive relationships with work, money, food, sex, risk, religion and the Internet are being embraced within the rubric of addiction. In the latter, people speak of being addicted to everything from chocolate to golf. This over-extension of addiction from its precise biological origins to its use as a broad metaphor for behavior that is pleasurable, repetitive, and potentially life disrupting, while troubling and perhaps inevitable, has important implications for the future of professional practice in addiction counseling.

There will likely be a growing movement to expand the range of historically private behaviors regarding which those working in the addictions field will be held professionally accountable. When does a counselor weigh too much or too little to work in addiction treatment? When does an addiction counselor's visit to a casino on his or her own time become a professional practice issue? Does the counselor working 60 hours a week deserve an award for this behavior or an admonishment and referral to the employee assistance program? The list is potentially unending, and that is the point.

Professional service fields tend to mirror the problems of their service consumers. Yes, the addictions field has a historical propensity for black-white thinking and excess behavior! We will need to manage this propensity actively if the conceptual boundaries of addiction continue to erode. Defining the nexus—the point of connection—between private behavior and professional performance will be a difficult task as the field continues to evolve and redefine itself.

Acknowledgments

I would like to thank Joe Gay, Renée Popovits, Thomas Ramseyer, Jason Schwartz, Jerry Seaman, and Dave Sharar for their helpful comments and suggestions on the issues discussed in this paper.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Sanders, T., Sanders, M. & White, W. (2006). "When I Get Low, I Get High": The portrayal of addiction and recovery in African American music, *Counselor*, 7(6), 30-35. Posted at **www.williamwhitepapers.com**

"When I Get Low, I Get High"
The Portrayal of Addiction and Recovery in African American Music

Tanya Sanders, Mark Sanders and William White

Important experiences in the life of a people are expressed through the cultural media of language, music, literature, dance, and art. As part of a larger project focusing on the history of addiction and recovery in African American communities, the authors investigated how the experiences of addiction and recovery have been portrayed within African American music. Through the major Internet web sites specializing in musical lyrics, we identified 145 songs released between 1924 and 2006 that focused on alcohol and other drug (AOD) intoxication, addiction, or recovery. The review spanned the genres of blues, jazz, rock n' roll, rhythm and blues, rap and Gospel music. This article summarizes the findings of that review and explores implications for the treatment of African American clients.

"Blues and Booze" (1920s and 1930s)

Isolated reports of African Americans addicted to alcohol date to the late 1700s, but sobriety was the norm within African American communities until alcohol-related problems significantly increased during the era of American Prohibition (the 1920s) (Christmon, 1995). This shift followed mass migration of African Americans into northern cities in the early twentieth century, diminished influence of the traditional Black church, and the infusion of alcohol into African American communities. During Prohibition, White criminal syndicates placed their bootlegging operations, speakeasies, cabarets, after-hours clubs, houses of prostitution, and gambling joints in predominately Black communities (James & Johnson, 1996). As alcohol and its related problems seeped into African American communities, local musicians detailed the stories of those problems in song. Ma Rainey lamented in "Blues and Booze" (1924) that she "spent every dime on liquor", but that she had to "have the booze to go with these blues". Ida Cox in "Booze Crazy Man Blues" (1928) expressed fear that her "sweet daddy" was going to let booze carry him to his grave. As the 1930s approached, Bessie Smith expressed the pain and isolation that could follow on the heels of liquor, champagne and wine in her riveting blues rendition, "Nobody Knows You When You're Down and Out" (1929).

The 1930s brought growing concern about alcoholism and its effects on the individual and family in such songs as Lonnie Johnson's "Low Down St. Louis

Blues" (1931), Lucille Bogan's "Drinking Blues" (1934), and Scrapper Blackwell's "Bad Liquor Blues" (1935). Joshua White confessed in "Pigmeat and Whisky Blues" (1935) to waking with a snake "crawlin' out that whiskey bottle, talkin' just like a natural man" and ends his song with the pledge "I ain't gon' drink no more liquor, doggone my whiskey-drinkin' soul."

The music of the 1930s also signaled new drug patterns in the African American community. Cab Calloway's "Kickin' the Gong Around" (1931), "The Man from Harlem" (1932), and "The Reefer Man" (1932), as well as Jazz Gillum's "Reefer Head Woman" (1938) signaled increased marijuana and cocaine use. Ella Fitzgerald summarized the central role of alcohol and other drugs in African American communities during the 1920s and 1930s in her 1938 blues anthem, "When I Get Low, I Get High".

"Beer Drinking Baby" to "Junker's Blues" (1940s-1950s)

World War II caused a precipitous drop in the production of African American music and in alcohol and drug-related musical themes within the songs of this period. Concerns about drinking expressed in the lyrics of African American music in 1940s focused primarily on women. Merline Johnson's "Bad Whiskey Blues" (1947) recounts the loss of her boyfriend due to her drinking, but she laments, "I can't help it, I would drink until the end." Billy Valentine complains that his "Beer Drinking Baby" (1949) wants to do nothing but drink day and night, raise hell and fight.

Following the Second World War, heroin use exploded in African American communities. Claude Brown (1965) vividly described the "shit plague" that hit Harlem and other New York neighborhoods in the 1950s. The changing racial profile of the American narcotic addict was reflected in admissions to the federal narcotics hospital in Lexington, Kentucky. African American admissions rose from 9% of admissions in 1936 to 52% of admissions in 1955 (Lowry, 1956). By the late 1950s, African American music was conveying the stories from this plague in songs such as Champion Jack Dupree's "Can't Kick the Habit" (1959) and "Junker's Blues" (1959).

The urban environment of the post-World War II America produced a "hipster" culture in which social detachment and emotional control were adopted as a style of liberated protest. The "viper" (marijuana user) and the "righteous dope fiend" (functional heroin user) became distinctive roles within African American communities and within the growing jazz subculture (Finestone, 1957; Sutter, 1966). First-hand accounts of the early hipster scene, such as "Mezz" Mezzrow's "Really the Blues," describe a subculture awash in alcohol, marijuana, opium, morphine, and heroin. The prominence of illicit drugs in this subterranean subculture became periodically visible in the drug-related arrests (e.g., Louis Armstrong, John Coltrane, Miles Davis) or deaths (e.g., Charlie Parker, Billie Holiday) of prominent jazz artists.

"Cloud Nine" to "King Heroin" (1960s-1970s)

African American music of the 1960s and 1970s continued to portray the celebratory function of alcohol in songs such as Lonnie Johnson's "Fine Booze And Heavy Dues" (1962), John Lee Hooker's "One Bourbon, One Scotch, One Beer" (1966), and Jimmy Rogers' "Sloppy Drunk" (1972). These songs did hint that such celebrations could evoke a personal price.

From the 1960s through the early 1980's, African American song lyrics tended to be suggestive and mysterious in describing drug use. Songs such as Sly and the Family Stone's "I Want to Take You Higher" (1969), Stevie Wonder's "Too High" (1973), Bob Marley's "I Shot the Sheriff" (1974) and "Easy Skanking" (1978), the Temptations' "Cloud Nine" (1969), and Laid Back's "White Horse" (1983) all suggested being under the influence of a substance without explicitly describing drug use. Rick James' 1978 song "Mary Jane" further

typifies such suggestiveness as he sings his love for Mary Jane and her ability to turn him on and take him to paradise when he is feeling low. Jimi Hendrix's "Purple Haze" (1967), the Temptations' "Psychedelic Shack" (1970) and Gil Scott-Heron's "Angel Dust" (1978) reflected the broader polydrug experimentation of the era.

Not all African American music of the mid-twentieth century treated drug use subtly. James Lee Hooker's "Kick Hit 4 Hit Kix U" (1970) was a eulogy to Janis Joplin and Jimi Hendrix as well as a challenge to addicts to kick their habits before they shared a similar fate. James Brown's 1972 "King Heroin" was an in-your-face warning about a drug that could make people forsake everything of previous importance in their lives. The song ended with a prediction of the fate of those who felt they were stronger than heroin.

Mount the steed!
And ride him well
For the white horse of heroin
Will ride you to Hell!

"8-Ball" to "Street Lobotomy" (1980s-present)

The devastating effects that the cocaine epidemic of the 1980s and 1990s unleashed on African American families and communities broke into public consciousness through a series of cocaine-related events: Richard Pryor's self-immolation (1980), the deaths of Len Bias and Don Rogers (1986), the damaged athletic careers of Dwight Gooden, Daryl Strawberry, and Dexter Manley and the public fall from grace of such African American political celebrities as Marian Barry. African American music and film celebrities of this era who also experienced substance-related incidents included Marvin Gaye, Rick James, James Brown, Whitney Houston, Dionne Warwick, and Martin Lawrence. While these high profile cases spawned unending media attention, the poorest African American communities experienced a crack cocaine epidemic, proliferating illicit drug markets, unprecedented patterns of crime and violence, and the transformation of the criminal justice and child welfare systems into occupying institutions. These changes unfolded just as a new stylized form of storytelling—rap music— and a broader "Hip Hop" culture were spreading through African American urban communities. It was inevitable that cocaine and its transformation of street life would be featured prominently in this new instrument of cultural expression.

Rap (particularly gangsta rap) featured alcohol and drug themes more prominently than any previous musical genre. To illustrate this influence, of the 145 songs we identified between 1924 and 2006 that prominently contained alcohol and drug themes, 106 (mostly rap songs) were released after 1980. Between 1979 and 1997, rap music songs with references to alcohol increased fivefold (from 8% to 44%), those exhibiting positive attitudes toward alcohol rose from 43% to 73%, and brand name mentions increased from 46% to 71%. There was also a significant increase in songs by rappers such as Jay Z, Puffy Combs, and Kanye West extolling exclusive brands of champagne and liquor. This marked a shift from a celebratory function of alcohol and drug use to the use of particular substances to signal glamour and wealth—a linkage fueled by the alcohol industry's use of rap music stars such as Ice Cube, Geto Boys and YoYo to promote expensive alcohol products (Herd, 2005).

Alcohol-themed rap songs of this era include NWA's "Drink it Up" (1987), Afroman's "Let's All Get Drunk Together" (2001) and "Colt 45" (2004), 50 Cent's "Got Me a Bottle" (2002), Tweet's "Drunk" (2002), and Tupac Shakur's "Hennessey" (2004). Typical of the rap songs that prominently featured illicit drug use were NWA's "8-Ball" (1989), Bone, Thugs, N-Harmony's "Smokin Budda" (1990), Cypress Hill's "Light Another" (1991), Dr. Dre's "Puffin On Blunts And Drankin Tanqueray" (1992) and "Blunt Time" (1996), Robert Plunkett's "Crack Smokin' Woman" (1996), Notorious BIG's "Ten Crack Commandments" (1997), Jay-

Z's "Dope Man" (1999), and Afroman's "Dopefiend" (2000). While some rappers glorified their transformation from drug dealers into millionaire rappers, others, such as Chuck D, lead singer for Public Enemy, expressed through songs like "Night of the Living Bashead" (1998) and "1 Million Bottlebags" (1991) that drugs and alcohol were destroying the Black community.

Themes and Implications

Music is a component of both the culture of addiction and culture of recovery (White, 1996), and reflects the African American community's ambivalent and evolving relationship with alcohol and other drugs and the functions substance use has served for African Americans.

A pervasive theme in African American music is the use of alcohol and drugs as a balm for personal and cultural pain. Songs from Ella Fitzgerald's "When I Get Low I Get High" to Tupac Shakur's "Pour Out A Little Liquor" (1994) portray the ritualized use of intoxicants to blunt emotional pain, assuage grief, and ritually honor the passing of loved ones. The portrayal of alcohol as an emotional anesthetic dates to Lucille Bogan's "Drinking Blues" (1934) in which the central character's heart "*is achin', and whiskey's all it's takin'.*" Such pain may be either personal or cultural. Maria Yellow Horse Braveheart (2003) describes a similar pattern of ritualized alcohol use through which Native Americans have medicated the pain of prolonged historical trauma. Each African American client has a "song to sing" (a story to tell), and these songs are filled with cultural as well as personal pain. Talking about historical oppression and present-day racism as well as talking about addiction and recovery within those contexts are best viewed by the counselor, not as defocusing, but as a potentially crucial dimension of the recovery process for many African Americans.

A second theme is the use of alcohol to socialize, celebrate, and signify (assert status). There is a distinct shift in emphasis from the portrayal of alcohol as a balm in the blues genre to the portrayal of alcohol and other drugs as status symbols within rap music. African American music contains vivid portrayals of the personal experience of addiction (particularly the loss of freedom and control) and life within the African American drug culture. A distinct feature within the latter is the depiction of the drug dealer as a hero and anti-hero in songs such as Cab Calloway's "The Man from Harlem" (1932), Curtis Mayfield's "The Pusherman" (1972), and Notorious BIG's "Ten Crack Commandments" (1997).

The role of the dealer and the broader themes of sexuality, criminality, violence and financial status that pervade rap music all suggest a search for manhood. Counselors share with us that they find it difficult to reach young African Americans who are a part of the hip-hop culture. The music of that culture can provide a bridge to understanding and empathy. Listen to the themes of these songs and consider that many successful rap artists—Tupac Shakur, Eminem, Jay-Z, Notorious BIG, Nelly, 50 Cent—were all reared without the active involvement of their fathers. Young African American men who have struggled to define their manhood in addiction will be similarly challenged to define their manhood in recovery.

Warnings of the effects of addiction on self (insanity and death), family (conflict and estrangement), and community (loss of connectedness, violence) also have a long history in African American music, although less prominent in rap music than earlier genres. Cautionary tales of recent decades combine admonitions to stop shootin', smokin', and swallowin' (James Lee Hooker's "Kick Hit 4 Hit Kix U", 1970) with messages to "get your mind together" (James Brown's "King Heroin", 1972) and "make some changes" (Tupac Shakur's "Changes", 1998). Other songs with a distinct anti-addiction message include Gil Scott-Heron's "The Bottle" (1974) and "Angel Dust" (1978), Prince's "Pop Life" (1985) and, as earlier noted, Public Enemy's "Night Of The Living Basheads" (1988) and "1 Million Bottlebags," (1991).

African American music has celebrated, cautioned and condemned alcohol and drug use, but has until recently been silent on broader patterns of abstinence, moderation, and recovery. It is only recently that stories of resilience in the face of addiction and stories of recovery have appeared in the lyrics of African American music. A poignant example of this trend is Tupac Shakur's homage to his mother in "You are Appreciated" (1995).

> *And even as a crack fiend, mama*
> *You always was a black queen, mama*
> *I finally understand*
> *for a woman it ain't easy tryin to raise a man*
> *You always was committed*
> *A poor single mother on welfare, tell me how ya did it*
> *There's no way I can pay you back*
> *But the plan is to show you that I understand*
> *You are appreciated*

As more prominent African Americans become public about their recovery from addiction (e.g., Whoopi Goldberg, Samuel Jackson, Natalie Cole, Jada Pinkett Smith, and Mary J. Blige), recovery themes will likely be reflected in their future work.

We found few African American song lyrics explicitly about addiction recovery, but we would be remiss in failing to acknowledge the role Gospel music has played in the lives of African Americans in recovery. With its themes of redemption, rebirth, forgiveness, and gratitude, and its deep historical subtexts of resistance, liberation and survival, African American Gospel music strikes powerful chords among many African Americans seeking recovery. The authors have interviewed numerous African Americans in faith-based recovery who report that the messages of hope, renewal and reconnection in the music are as important to their recoveries as religious doctrine. As one person stated, "As a recovering cocaine addict, I need a religion I can feel. I can feel Gospel music and it gives me hope."

African American clients seeking recovery are bombarded by musical cues that celebrate drinking and drug use (Brookshire, et al., 2003). This suggests the potential benefit in exploring isolation strategies (minimizing cue exposure), substitution strategies (replacing intoxication cues with sobriety cues via recovery-themed music), or reframing strategies (altering the meaning and response to pro-drug messages) (White, 1996). The influence of such messages in African American music can be weakened or neutralized by reframing addiction within africentric metaphors (e.g., slavery, genocide) and portraying recovery as an act of cultural survival as well as personal transformation.

The recovery of African Americans can be enriched by exposure to the history of African American resiliency and recovery and by exposure to living proof of long-term recovery and the diversity of recovery styles within the African American community—including exposure to prominent musicians and artists in recovery. African American songwriters, musicians, singers and producers could help build cultures of recovery in the African American community by expressing their recovery experiences and service work through their music.

African Americans have expressed their relationships with alcohol and other drugs through multiple musical genres. The stories conveyed through the medium of song reveal the wounds these substances have inflicted on African Americans and their families and communities, but they also stand as testimony to deep sources of resilience and recovery within African American communities. Music as a healing testimony will increase as the prevalence and visibility of recovery grows within African American communities across the country. As culturally competent counselors, we can serve as conduits through which such recovery stories reach our clients.

Acknowledgement: Support for research on this article was provided by the Great

Lakes Addiction Technology Transfer Center (funded by the Substance Abuse and Mental Health Services Administration / Center for Substance Abuse Treatment). All opinions expressed here are solely those of the authors.

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Citation: White, W. & Kilbourne, J. (2006). American women and addiction: A cultural double bind. *Counselor*, 7(3), 46-51. Posted at **www.williamwhitepapers.com**

American Women and Addiction: A Cultural Double Bind

William L. White and **Jean Kilbourne**

There is a long, paradox-filled history of addiction among American women. An ever-increasing menu of psychoactive drugs has been aggressively promoted to women amidst promises that these products could deliver physical sedation and emotional anesthesia and help one attain and or maintain an otherwise unachievable standard of beauty. At the same time, women who become addicted to these very drugs have faced intense shame and stigma. Women in recovery have charted pathways between these twin insults by exposing the enticements of the institutional drug peddlers and bravely stepping forward to challenge the cultural caricature of addicted women. This article highlights some of the themes within this history and their clinical implications for addiction professionals.

A History of Promotion

The alcohol, tobacco and pharmaceutical (ATP) industries have manufactured psychoactive substances specifically for women for more than two centuries, from opium-, cocaine- and alcohol-laced products for "female problems"(e.g., Lydia Pinkham's Vegetable Compound) and bottles emblazed with the words "Woman's Friend" to today's feminized tobacco brands (Virginia Slims, Eve, Max, Satin, Capri and Misty), alcohol products (light beer, wine coolers, pre-packaged cocktails, and sweet drinks) and mood-altering prescription drugs. These industries have mastered the use of psychological research in advertising design. They use enticing psychological symbols to encourage initial drug use and then rely on pharmacology (tolerance and withdrawal) and social reinforcement to increase and sustain consumption over time.

Using extremely well financed and sophisticated marketing campaigns, the ATP industries pathologize female bodies and female experience (e.g. by portraying women as physically imperfect, emotionally distressed, helpless and incompetent) and then aggressively offer products that promise to make women physically, emotionally and spiritually whole. The seductive messages within the advertisements for these products were and are inescapable and relentless (Examples from Kilbourne, 2000, 2004; Jacobson, Atkins & Hacker, 1995):

1. *Drugs enhance your beauty*.
    - Lucky Strike tag line: "To keep a slender figure, no

one can deny. Reach for a Lucky instead of a sweet"

- Misty tag line: "Slim 'n Sassy"
- Portrayal of the cigarette as a stylish beauty accessory.

2. *Drugs encourage self-acceptance*.
    - A Michelob ad features headlines such as "Body Hair Horror" and "Blast Jiggly Hips and Thighs" beside a photo of Michelob beer and the message "They say improve yourself. We say crack open a cold, clean, extremely smooth Michelob Light and enjoy yourself. Just the way you are. Relax. You're OK. Improve your beer."
3. *Drugs are empowering and liberating*
    - Virginia Slims' tag lines: "You've come a long way, baby" and "Find your voice."
    - Winston tag line: "Here's to women who can light their own cigarettes."
    - "Politically correct by day. Bacardi by night."

4. Drugs can improve your sex life and your relationships with men

- Cuervo tag line: "Bad girls make good company"
- Martell tag line: "Be at least capable of bad"

5. *Smoking and drinking are sophisticated and pleasurable*
    - Cazadores tequila ad portraying an attractive women smoking a cigar while clad only in a man's shirt, with the tagline "Expect the best…Drink the Finest."
    - Images of young attractive couples illustrating the Newport tag line "Alive with pleasure"

6. Drugs can substitute for a good relationship.

- Winston: "Until I find a real man, I'll settle for a real smoke"
- "Riunite…like love it's pure and natural"
- Sultry young woman gazing over a drink above a photo of a pack of Camel cigarettes and the tag line "What you're looking for."

7. *Drugs relieve stress and provide escape from difficult emotions and relationships*
    - "When Junior's fighting rates a scold, why be irritated, light an Old Gold"
    - Eve cigarette tag line: "It's a few minutes of your own"
    - Benson & Hedges tag line: "Peace and Quiet"

Alcohol, tobacco and over-the-counter drug advertising has always reached women through mainstream media outlets. Until recently, however, selling prescription psychoactive drugs to women has required elaborate efforts to target and influence physicians. A study conducted at the Medical College of Pennsylvania examined the portrayal of women and men in ads for antidepressants that appeared in the *American Journal of Psychiatry* (AJP) and the *American Family Physician* (AFP). The ratio of females to males in ads for antidepressants in the two journals was 5:1 in AJP and 10:0 in AFP (Hansen & Osborne, 1995).

The ATP industries' investment in targeted advertising assures that virtually all American women will be exposed to their products. The historical patterns of addiction among American women parallel these promotional strategies, from narcotic addiction among women in the nineteenth century to the rise in alcohol and nicotine addiction over the course of the twentieth century. Throughout this history, male-

dominated industries and professions have delivered psychoactive drugs to women all across the country—sedating them, tranquilizing them, shaming them for their bodies and their emotions, offering drugs as solutions to these "problems," and then profiting hugely from their sale (Kandall & Petrillo, 1996).

A History of Shame

Women had socially approved, regular access to alcohol in Colonial America, but such access and acceptance declined in the nineteenth century amidst growing alcohol problems and a flourishing temperance movement. By the mid-1800s**,** women became the champions of abstinence and women addicted to alcohol were portrayed as pitiful and depraved creatures. As social stigma related to women and alcohol increased, drinking became hidden within the home and masked behind women's use of a growing menu of alcohol-based "medicines." The need for secrecy in drinking created a market for clever devices such as thin rubber capsules resembling grapes which could be filled with wine or spirits, placed in an opera glass case, and surreptitiously slipped into the mouth and crushed with the teeth with the skin then slyly discarded (Clum, 1888). Some women were also reported to be "slaves to cologne" (drinking alcohol-based perfumes and toilet waters)(Kelley, 1899).

Addiction to alcohol and other drugs brought shame and social disgrace to women. Accounts of such attitudes emerge in tandem with the earliest accounts of addiction. In 1784, Dr. Benjamin Rush lamented of the female drunkard, "Who can measure the shame and aversion which she excites in her husband?" (Rush, 1784). The shame was so great that addicted and recovering women had no voice and no identity. The first (1842) purported addiction confessional by a female inebriate (*Confessions of a Female Inebriate)* was actually penned by a man *(*Isaac Shephard). Addicted women frequently entered treatment in inebriate homes and private addiction-cure institutes under assumed names, with even their physicians not knowing their true identity. This practice continued well into the 1900s with institutions like the Murray Cure Institutes in Minneapolis promising prospective women patients that they could be "treated privately in their rooms" and "remain unknown throughout their stay" (AMA Archives, Box 0033-12).

In 1877, Thomas Doner compared societal attitudes toward men and women suffering from alcoholism.

> *Men can reform. Society welcomes them back to the path of virtue…But, Alas! For poor women who have been tempted to sin by rum. For them there are not calls to come home, no sheltering arm; no acceptance of confessions and promises to amend…How seldom we attempt to reach and rescue her! For her there is no refuge (pp. 19-20).*

Opiate addiction among women was culturally hidden in the nineteenth century in spite of the fact that most opiate addicts at that time were women (Kendall & Petrillo, 1996). Many affluent women possessed jeweled syringes disguised as charms and worn on their clothes. (The less affluent could order a syringe kit from the Sears and Roebuck catalogue for $1.50.) Nonetheless, female addiction to opiates, cocaine, chloral, chloroform and ether was hidden but for occasional confessionals in medical journals (The chloroform habit, 1884) or portrayals in popular fiction (e.g., in *The House of Mirth).*

Negative attitudes toward women who drank intensified through the early 1900s, but began to lessen during the Prohibition era as new social institutions catered to women (the cabaret, the nightclub, the dance club) and as young women embraced alcohol and cigarettes as symbols of liberation. The stigmatization of alcoholic and addicted women did not lessen, however. These women remained invisible and voiceless with only a few confessional biographies published anonymously (e.g., *No Bed of Roses: The Diary of a Lost Soul* by O.W.)(1930). The

attitude toward women entering Alcoholics Anonymous in the 1940s was revealed by such journalistic headlines as "Women Drunkards, Pitiful Creatures, Get Helping Hand" and "AA: No Booze but Plenty of Babes." This attitude intensified during the 1950s amidst lurid portrayals of alcoholic women in the popular press.

Social stigma attached to addiction briefly abated in the 1970s, but further intensified in the 1980s and 1990s as addiction in both sexes was restigmatized, demedicalized and recriminalized. Evidence of this trend was evident in the increase of drug-related incarceration of women between 1986 and 1991 – an increase of 241% for Caucasian women, 328% for Latinas and 828% for African-American women (Chavkin, 2001). The collision of sexism**,** racism, classism and addiction exacted, and continues to exact, a high toll in poor communities of color.

Addicted women were stigmatized primarily by two myths: that they were unrestrained sexually and that they were bad mothers. The highly sexualized image of the alcoholic woman was deeply ingrained in the 1950s through book covers with nude or partially clad figures bearing titles and descriptions such as *Alcoholic Wife* (1950). "How should he handle his alcoholic wife…Beat her? Cater to her inflamed desires? Overlook her drunken intimacies with other men?" (1950), *Tormented Women: A Frank Revealing Study of Women Degraded by Alcohol* (1959), and *Alcoholic Woman* ("Drink turned her into a sex-crazed animal!")(1959). The theme of maternal irresponsibility reached its peak in the hysteria over "crack babies" in the late 1980s—a period filled with misinformation on the effects of prenatal cocaine exposure (Chavkin, 2001). Stepping forward to challenge these images required enormous courage, but there is a rich history of women who did just that.

A History of Resistance and Recovery

It would be easy to portray women as passive victims of ATP industry exploitation and cultural bigotry, but the actual story is much more complex and interesting. Women began banding together for mutual support for recovery between 1840 and 1880 (Martha Washington Society, Daughters of Rechab**,** Daughters of Temperance, Sisters of Samaria, Daughters of Samaria, Ladies Dashaway Association) and the Woman's Christian Temperance Union were all vocal advocates for specialized treatment facilities for women. Such facilities began in 1869 and increased in number through the late 1800s (Martha Washington Home, Temple Home, New England Home for Intemperate Women, St. Savior's Sanitarium). During the late nineteenth century, addiction medicine specialists such as Drs. Agnes Sparks and Lucy Hall castigated the promotion of addictive medicines to women and championed the special needs of addicted women through their professional writings in the *Journal of Inebriety* and their presentations before the American Association for the Cure of Inebriety (White, 1998).

In the 1940s the first women in Alcoholics Anonymous braved challenges that women could not be alcoholics and male fears about the disruptiveness of their presence to establish women's groups within A.A. It was during that same decade that recovering women stepped forward publicly to educate America about alcoholism and women. Their stories inspired new literature (*Breakdown*, 1946), new films (*Smash-Up: The Story of a Woman!*, 1947) and new clinical texts (*The Alcoholic Woman: Case Studies in the Psychodynamics of Alcoholism, 1956*). In 1980 Marian Sandmaier published the groundbreaking *The Invisible Alcoholics: Women and Alcohol Abuse in America*.

Between 1944 and 1980, a series of prominent women publicly declared their recovery from addiction to alcohol and other drugs and spoke out on the misconceptions of addiction and women. Included among celebrity women who disclosed their recovery status were public health advocates (Marty Mann), actors (Lillian Roth, Mercedes McCambridge, Elizabeth Taylor, Mary Tyler Moore, Drew Barrymore, Melanie Griffith and Mariette Hartley),

musicians (Grace Slick, Judy Collins, Natalie Cole, and Bonnie Raitt), comedians (Whoopi Goldberg and Brett Butler), writers (Susan Cheever), TV personalities (Linda Ellerbee), models (Naomi Cambell and Kate Moss) and political figures (Ann Richards, Joan Kennedy, and Kitty Dukakis). No disclosure exerted more profound cultural ripples than that of First Lady Betty Ford. Her story put a face and voice on the recovering woman that challenged two centuries of stereotypes and inspired many addicted women in America to seek treatment. That more than half of those treated at the Betty Ford Center today are women stands as living testimony to the lasting effects of her courage.

Women have often resisted the seductive calls of the ATP industries, have had the courage to construct their own recovery styles and have stepped forward to publicly challenge the misconceptions surrounding addiction and women. The history of addiction in America is a history of exploitation and a history of stigma, but it is also a history of resistance, recovery and advocacy.

Clinical Implications

So what are we to make of this complex history? There would seem to be several clinical implications that flow from this summary. Perhaps the first and most important is the effect of this history on addicted women. ATP advertising creates a "culture of denial" by masking growing alcohol and other drug problems behind a veil of normalcy (Kilbourne, 2004). Morally laden stereotypes that define female addiction in terms of sexual promiscuity and maternal failure similarly serve to make it more difficult for women to identify a problem and seek help. These influences contribute to the late stage at which addicted women often seek help, and assure that most women will arrive at treatment encased in shame-induced protective armor.

If we are to reach women at earlier stages of addiction, we must challenge these images and launch assertive outreach programs to reach women in need of treatment and recovery support services. If we are to treat addicted women effectively, we must help answer the "why me?" question in terms other than character and morality. Addiction and recovery of women are best viewed in the broader social context of their lives as women—a context that involves restrictive gender roles, vulnerability for victimization, targeting by predatory ATP industries, and a daily assault by demeaning cultural stereotypes. We must also prepare women for the cultural obstacles they will encounter as women in recovery.

This history also suggests that addiction is closely connected to women's experiences of disempowerment through systems of socialization and developmental experiences (e.g., sexual abuse) that set women up to hate their bodies and discount the legitimacy of their own emotional experience. The best of gender-based treatment focuses on helping women understand and transcend such culturally inflicted wounds. Recovery for most women goes way beyond the removal of alcohol and other drugs from an otherwise unchanged life. Recovery offers women an opportunity to reconstruct their personal identities and interpersonal relationships based on a new understanding of their own personal stories and their shared story as women and as recovering women in America. The personal story of the transformative journey from addiction to recovery is nested in the larger story of how cultural experiences of women shape both addiction and recovery. Being available to assist with this sense-making process is the very essence of addiction counseling.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2006). Believe it or not: Strange tales from the history of addiction treatment. Posted at **www.williamwhitepapers.com**

HISTORY CORNER

Believe It or Not:
Strange Tales from the History of Addiction Treatment

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Efforts by professionals to "treat" alcoholism and other addictions have a long and colorful history. Alcoholics have been forced to drink their own urine and forced to drink wine in which an eel had been suffocated. They have been surreptitiously dosed with everything from mole blood to sparrow dung and subjected to the "Swedish treatment" in which everything they consumed and even their clothes and bedding were saturated with whiskey. They have been prescribed dietary treatments that included the apple, salt, grape, banana, onion, and watermelon cures. They have been fed gold, iron and bark to quell their appetite for alcohol.

Harm done in the name of good is an enduring theme in the history of addiction treatment. Even Dr. Benjamin Rush, the father of the American disease concept of alcoholism, treated alcoholics by blistering, bleeding, and unknowingly poisoning them with mercury-laden medicines. In the 19th century, alcoholics and addicts were routinely prescribed alcohol, narcotics, marijuana, sedatives, stimulants, and hallucinogens. Dr. J.B. Bently prescribed cocaine by the pound as a treatment for alcohol and morphine addiction and reported, as a testament to the cocaine=s effectiveness, that his patients were requesting additional quantities of cocaine and that they had completely lost their appetite for alcohol and morphine. There were "bromide sleep treatments" for narcotic withdrawal that killed 20% of patients undergoing the procedure. There was the physician who, noting that alcohol intake decreased among his patients suffering active stages of gonorrhea, recommended medically infecting alcoholics with gonorrhea as a way to save the expense of sanatorium treatment.

Through the first half of the 20th century alcoholics and addicts were subjected to legally mandated sterilization on the grounds that it would prevent the birth of future generations of alcoholics and could

treat the underlying physical causes of alcoholism. There were early 20th century "serum therapies" that involved raising blisters on the addict's skin, withdrawing the serum from the blisters, and then injecting this serum into the addict during withdrawal. There were also withdrawal therapies in the 1930s utilizing substances that could induce psychoses of up to two months duration.

Alcoholics and addicts were indiscriminately exposed to whatever was in vogue within the broader arenas of medicine or psychiatry. The 1940s and 1950s witnessed addiction treatments that included electroconvulsive and insulin shock therapies and the use of psychosurgery (the prefrontal lobotomy). At least one alcoholic commended the latter, reporting that, following the surgery, he could get "twice as tight on half the hooch." The 1950s also witnessed the use of methamphetamine as a medically prescribed substitute for alcohol and heroin—a practice that nurtured the subsequent growth of a methamphetamine injection subculture.

It is easy to look back with condescension at the practice of treating morphine addiction with cocaine or alcoholism with practically every other psychoactive drug. It is easy to look back with outrage at the mandatory sterilization of alcoholics or their being blistered, bled, and subjected to invasive interventions from psychosurgery to shock therapies. But an important lesson is that the harmfulness of these interventions was not visible in their own time. History demands that those seeking treatment for addiction to alcohol and other drugs honor the adage, "Let the buyer beware" and demand that treatment providers adhere to the ultimate ethical mandate: "First do no harm!"



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Reis, T. (2006). Images from the Brown University Alcohol and Addiction Studies Collections. Addiction, 101, 788-792. Posted at **www.williamwhitepapers.com**

Photographic Essay
Images from the Brown University Alcohol and Addiction Studies Collections

William L. White and Tovah Reis

Over the past decade, Dr. David Lewis of Brown University's Center for Alcohol and Addiction Studies, has led an effort to assemble one the of the world's largest collections of alcoholism and temperance literature. In this brief essay, the authors will describe the alcohol-related collections at the Brown University Library and use images from these collections to convey their topical scope.

The core of the Brown University Alcohol and Addiction Studies Collections is the Chester H. Kirk Collection on Alcoholism and Alcoholics Anonymous. This collection came to the university in 1995 through a contribution by Chester H. Kirk that enabled Brown University to purchase more than 15,000 pieces of alcoholism and temperance literature. The Kirk Collection holdings were the fruits of two decades of acquisitions by Charles Bishop, an antiquarian book dealer and coauthor of a guide to the published literature on Alcoholics Anonymous. The Kirk Collection added great depth to an already significant body of alcohol and temperance literature within the Brown University Library.

The Kirk Collection holdings range chronologically from a 1493 depiction of a drunken Noah in the Nuremburg Chronicle (Plate One) through the first American book on alcoholism (Anthony Benezet's 1774 The Mighty Destroyer Displayed) (Plate Two) to late twentieth century texts, journals and pamphlets on alcoholism. Topically, the collection focuses on alcohol and alcoholism, with the bulk of the collection made up of works on temperance and prohibition and the history of Alcoholics Anonymous. However, buried within these larger topical concentrations lies a large number of nineteenth century texts on inebriety and its treatment. The majority of the materials in the Kirk Collection are from the United States, but the collection also contains materials from Canada, England, Australia, and New Zealand as well as many texts that examine alcohol use and alcohol policies around the world.

The story of alcohol use, alcohol problems and efforts to prevent and treat alcohol problems is told within the Kirk Collection through a variety of media: books (Plate Three), journals (Plates Four and Five), newsletters and newspapers (Plate Six), pamphlets (Plates Seven and Eight), A.A. memorabilia (Plate Nine), sheet music (Plate Ten), photographs (Plates Eleven and Twelve), glass slides, posters,

video and audiotapes, and an exotic assortment of artifacts. Since its acquisition in 1995, other collections have been acquired that complement the Kirk Collection. These collections include the:

- Dr. Bob Archives—a collection of over 5,000 items (books, photographs, memorabilia, manuscripts, and personal letters) related to the early history of Alcoholics Anonymous that were purchased from the family of Dr. Robert Holbrook Smith (Plates Thirteen and Fourteen).
- Rutgers Anti-Saloon League Collection of Foreign Temperance and Addictions Studies Periodicals—a collection of more than 15,000 items from the Anti-Saloon League that was transferred from the Center of Alcohol Studies library at Rutgers University to Brown University in 1999.
- Marty Mann NCADD Collection—a collection of Board minutes, official correspondence, photographs, films and audiocassettes related to the history of the National Council on Alcoholism and Drug Dependence, Inc.
- Ernest Kurtz Collection on Alcoholism—a collection of source documents, notes and interviews (notes and recordings) used in the preparation of Not-God: A History of Alcoholics Anonymous.
- Clarence Snyder A.A. Collection—a collection of papers, correspondence and audiotapes detailing the early history of Alcoholics Anonymous group # 3 in Cleveland, Ohio.
- Rufus King Files—the books, papers and correspondence of the noted drug policy reformer donated to Brown shortly before his death in 1999.
- Papers of Dr. Dan Anderson and Dr. Jean Rossi —the published and unpublished articles, speeches and correspondence of two of the leading architects of the "Minnesota Model" of chemical dependency treatment.
- Papers from the "Just say No" campaign of Mrs. Nancy Reagan.

One of the major goals of assembling these collections is the transfer of historical materials from private hands to an environment where they will be accessible for interdisciplinary research. Descriptions and inventories of these collections are being prepared as a critical step toward achieving that goal.

Seen as a whole, the Brown University collections constitute one of the largest repositories of primary documents and artifacts on the histories of American alcohol problems, the American temperance movement and Alcoholics Anonymous. To enhance utilization of these materials, Brown University hosts interdisciplinary conferences to study these collections, posts papers based on research of the collections, offers fellowships to support students wishing to study these collections, and is digitizing material that is no longer copyrighted, e.g., the pamphlets from the Anti-Saloon League collection. These digitized items are available online at http://dl.lib.brown.edu/temperance/, as well as a Brown student's research paper on these pamphlets. Brown University also publishes the journal Culture Alcohol and Society (available online at http://www.brown.edu/Facilities/University_Library/libs/hay/collections/kirk/index.html). Additional information about the collection, including links to lists of books, journals and audiocassettes in the collections is available from: http://www.brown.edu/Facilities/Univesity/Library/libs/hay/collections/kirk/index.html.

For information about the Brown University Alcohol and Addiction Studies Collections, e-mail Tovah Reis at Tovah_Reis@brown.edu or call 401-863-3334.

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Plate 2: Mighty Destroyer Displayed, 1774
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Plate 4: American Temperance Magazine, 1833
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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Gasperin, D. (2006). Addiction treatment and recovery: A primer for criminal justice personnel. Springfield, IL: University of Illinois-Springfield Center for Legal and Policy Studies. Posted at **www.williamwhitepapers.com**

Addiction Treatment and Recovery: A Primer for Criminal Justice Personnel[1]

William L. White and David Gasperin

Introduction

For more than a decade, the Illinois Department of Transportation's Division of Traffic Safety, the University of Illinois-Springfield's Center for Legal, Policy and Administrative Studies, the Administrative Office of the Illinois Courts and Chestnut Health Systems research and training division (Lighthouse Institute) have been involved in training the criminal justice personnel who prosecute, sentence and supervise DUI offenders. As that training has progressed, we have explored questions about the role of addiction treatment in the rehabilitation of substance-involved offenders and how the criminal justice system can best link individuals to treatment, support treatment participation, reduce post-treatment criminal recidivism and enhance long-term recovery outcomes. The purpose of this primer is to offer tentative answers to these questions for the prosecutors, judges, probation officers and Secretary of State Hearing Officers who stand as a protective shield between substance-involved offenders and the citizens of Illinois.

Information from several sources provided an important skeleton for this primer: 1) an earlier monograph on *Management of the High-Risk DUI Offender* (White, 2003), 2) the Center for Substance Abuse Treatment's pamphlet *What is Substance Abuse Treatment*, 3) *Questions and Answers About Adolescent Substance Use Problems and their Treatment* (Risberg and White, 2003a,b) and 4) the Great Lakes Addiction Technology Transfer Center's monograph *The Varieties of Recovery Experience* (White and Kurtz, 2005).

Our focus in this primer is to summarize the best available scientific information on the treatment of offenders with substance use disorders. Where that evidence is lacking due to a shortage of funded studies on a particular issue, we have tried to summarize the latest thinking on that issue drawn from our own experience and the experience of criminal justice and addiction treatment personnel from around the country. We hope this primer will serve as a helpful orientation for new and long-tenured personnel working in the criminal justice system.

[1] Support for the development of this primer was provided through a grant from the Illinois Department of Transportation, administered by the Institute for Legal and Policy Studies, University of Illinois-Springfield.

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AOD Problems and their Resolution

What distinguishes substance use from a substance use disorder?

A significant portion of American citizens consume alcohol and others drugs during their lives, but only a much smaller portion of those individuals develop significant problems related to such use. Alcohol and other drug (AOD) problems vary in their course, spanning from adverse reactions to a single episode of AOD-intoxication, problems that span only a few months or years, and problems that span a significant period of one's life. Substance use disorders are distinguished by problems that meet the criteria of severity and duration. The current diagnostic system for substance use disorders, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), divides these disorders into two categories.

AOD-problems that meet DSM-IV criteria for substance abuse reflect clinically significant impairment marked by one or more of the following in the past year:

- repeated substance use that results in failure to perform major role obligations,
- repeated use in situations that are physically hazardous,
- repeated substance-related legal problems, and
- continued substance use in spite of adverse AOD-related problems.

AOD problems that meet DSM-IV criteria for substance dependence reflect clinically significant impairment marked by at least three of the following in the past year:

- tolerance (escalating dosage required to produce desired effect),
- withdrawal (physical/psychological distress and craving following drug cessation),
- loss of control (erosion of volitional control over quantity and duration of use),
- failed efforts to cease or reduce use,
- significant time involved in drug procurement, drug use and recovery from drug effects,
- social, occupational or recreational activities forsaken or reduced due to drug use, and
- continued use in spite of adverse physical or psychological problems caused by substance use (American Psychiatric Association, 1994).

It can be seen from these criteria that substance use disorders are distinguished from substance use by their consequences and distinguished from transient substance-related problems by their severity and duration.

How do people develop such disorders?

The development of a substance use disorder requires two conditions. The first condition involves forces that initiate excessive alcohol and other drug consumption. These are sometimes referred to as etiological pathways. The second condition involves those forces that operate to sustain excessive drug consumption over time. The former might be thought of as initiating factors (push forces); the latter can be thought of as maintenance factors (pull forces).

There are multiple etiological pathways that mark the migration from substance use to the development of a substance use disorder. These pathways can be thought of in terms of sources of personal vulnerability and span three categories.

Some individuals have increased biological vulnerability for substance use disorders (e.g., experience alcohol and other drugs as more rewarding) (Volpicelli, 2001). Such vulnerability can result from genetic predisposition (children with extensive, intergenerational family histories of substance use disorders have 4-5 times the risk of later development of a substance use disorder than children born in families without such histories)(Goodwin,1988). This pattern is variably referred to as "gamma species alcoholism" (Jellinek, 1960), "Type B" alcoholism (Babor, et al., 1992), "Type II alcoholism," "male-limited alcoholism" (Cloninger, 1987), and "primary alcoholism" (White, 1996). Biological vulnerability can also result from physical trauma to the brain and nervous system that alters what might have otherwise been a normal response to psychoactive drugs. In general, biological vulnerability is indicated by one or more of the following: a family history of AOD problems, atypically high or low tolerance to alcohol and other drugs, euphoric recall of first AOD use, evidence of neurological insult predating AOD use (e.g., history of seizure activity, sensory impairment, cognitive impairment), and radical personality change while intoxicated. There are also individuals with severe and often complex medical illnesses (particularly those triggering acute and chronic pain) who develop patterns of self-medication with alcohol and other drugs to alleviate the symptoms of such illnesses.

People can also possess psychological vulnerability for substance use disorders. This vulnerability is reflected in two patterns. The first involves people who are going through a major developmental crisis, e.g., divorce, death, occupational displacement, or other stressful event and increase their AOD consumption to ameliorate the distress associated with such events. The second pattern is seen in individuals with serious psychiatric illnesses whose excessive AOD use reflects one of numerous symptoms of such illnesses, an effort to hide or mask the existence of this stigmatized condition, or an effort to self-medicate symptoms of such an illness. Two common examples often seen in the criminal justice system illustrate this pattern of vulnerability. The first involves individuals with severe personality disorders whose excessive AOD use reflects a broader pattern of sensation-seeking, risk-taking, and boundary-testing as well as a reflection of a broader cluster of traits, including self-centeredness, impulsivity, poor problem solving and disregard for social and legal norms. The second pattern involves individuals with histories of childhood victimization whose AOD use serves to self-medicate. The sustained risk for AOD problems rises in tandem with particular traumagenic factors related to such victimization. These factors include:

- early age of onset of victimization,
- long duration of victimization,
- victimization by multiple perpetrators over time and across circumstances,
- victimization by trusted individuals,
- boundary-invasive forms of victimization, and
- failure to be believed or protected following disclosure of victimization.

A third category of vulnerability for substance use disorders involves environmental vulnerability. In this pattern, excessive AOD use emerges in response to one's relationship to his or her family, social, or cultural environment. This pattern spans individual's using drugs excessively to behaviorally express serious problems in the nuclear family (a common pattern among adolescents), individuals developing AOD problems within a subculture in which excessive AOD use is a ticket of membership and a source of identity, and individuals who are enmeshed in cultural patterns of (often male-based) excessive drinking. (See White, 2003 for a detailed description of the "species of substance use disorders," distinguishing characteristics and indicated treatment strategies.)

Biological, psychological and environmental vulnerability can serve to prime a pattern of excessive AOD use that over time can mature into a severe and life-threatening substance use

disorder. Risk for the development of substance use disorders increases when combinations of these risk factors appear in the life of a single individual.

The forces that maintain excessive substance use are often quite different than the forces that initiate such a pattern of use. Once a pattern of excessive AOD use has been initiated, other forces come into play to sustain that pattern over time. These can include such factors as the growing range of psychological needs met by drug consumption and enmeshment in a drug-enmeshed social network (a culture of addiction), but there is growing evidence that the most powerful of these sustaining forces involve brain adaptations induced by sustained drug exposure. Volitional control over whether to use or not use and how much to use once use starts rapidly diminishes as the brain is "hijacked" by these biological adaptations to sustained drug exposure (Dackis, & O'Brien, 2005; Shaham, & Hope, 2005).

By the time people present in the criminal justice system due to AOD-related problems, they often present with deeply imbedding clusters of initiating and maintenance factors that have matured into diagnosable substance use disorders. The fact that those with substance use disorders are not a homogenous population underscores the need for sophisticated assessment procedures, a broad menu of treatment strategies and recognition of multiple long-term pathways and styles of recovery.

How many people in the United States have a substance use disorder?

In 2002, a national household survey identified the prevalence of those U.S. citizens who needed treatment for a substance use disorder as well as those who had received such assistance that year. Based on this survey, the estimated number of persons aged 12 or older needing treatment of an AOD-related problem was 22.8 million (9.7 percent of the total population) (SAMHSA, 2003). Thirteen percent of Americans have met DSM-IV criteria for alcohol abuse or alcohol dependence some time during their lives; the 12-month prevalence rate for alcohol abuse and dependence among Americans is 4-5% of the population (Grant, 1997).

What percentage of people who need addiction treatment actually receive such treatment?

Of the 22.8 million people needing treatment, only 2.3 million (1.0 percent of the total population aged 12 or older; 10.3 percent of those who needed treatment) received treatment at a specialty substance abuse facility during the year preceding the survey (SAMHSA, 2003). There is evidence that only a quarter to a third of people who meet DSM-IV criteria for a substance use disorder receive specialized addiction treatment in their lifetime (Dawson, Grant, Stinson, et al, 2005; Cunningham & Breslin, 2004).

What is the profile of individuals treated for substance use disorders in the United States?

The National Institute on Drug Abuse reported the profile of 1.7 million treatment admissions in 2003. The dominant profile of persons entering treatment for a substance use disorder were being treated for problems with alcohol (23.2%), alcohol and another drug (18.7%), marijuana (15.4%), heroin (14.4%), crack cocaine (9.9%), amphetamines (7.7%), cocaine (3.5%) or other opiates (2.9%). Those admitted to treatment in 2003 were predominately White (61.8%), African-American (23.6%) and Hispanic or Latino (13.3%). Most were between 31-45 years of age (43.4%) or 21-30 (24.6%). Fifteen percent of those admitted to treatment were between age 12-20. (Source: http://www.drugabuse.gov/DrugPages/Stats.html)

The percentage of women admitted for treatment of a substance use disorder is increasing in the United States with women now representing 30% of national treatment admissions. Women also present with different drug choices. Women make up only 23.6% of alcohol admissions, but 50.9% of sedative admissions, 49.6% of tranquilizer admissions, 46.3% of other opiate admissions and 44.6% of methamphetamine admissions. (Source: http://www.whitehousedrugpolicy.gov/drugfact/women/)

Does this profile differ among those admitted to treatment in Illinois?

There were a total of 97,714 treatment admissions in Illinois in FY 2004. 33% of those admissions were women (30% nationally), and the primary drugs at the time of admission in their order of frequency were alcohol, marijuana, cocaine, heroin, methamphetamines and other opiates. The racial composition of 2004 treatment admissions in Illinois was 48% White, 41% African American, 9% Hispanic and 4% other. Adolescents made up 17% of all treatment admissions.

(Source: Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, FY 2004 Data Book. http://www.dhs.state.il.us/oasa/dasafy2004dataBook.pdf)

Does this profile differ for individuals referred from the criminal justice system?

Nationally, referrals from the criminal justice system to addiction treatment (compared to all admissions) are more likely to be male, younger, employed, report a primary problem with alcohol and have no prior history of treatment. (Source: http://www.oas.samhsa.gov/2k4/CJreferrals/CJreferrals.htm)

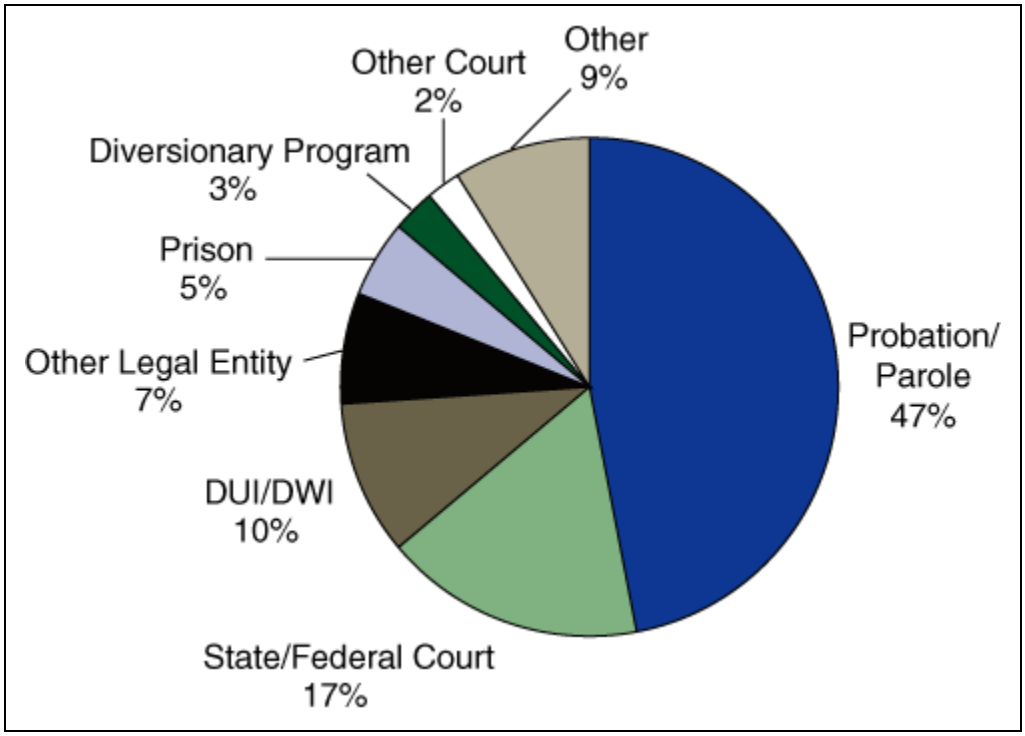
In Illinois, there were a total of 64,087 criminal justice (CJ) referred clients (not including TASC and DUI referrals). These referrals were predominately male (75%) with a slightly higher percentage of White referrals (50.6%) (compared to 37.4% for Blacks, 8.9% Hispanics and 3% for Other). Of the CJ referred clients in 2004, 82% were unmarried (never married, divorced, separated or widowed), 68% had a family income of less than $7,400 and 49% were unemployed at the time of their admission to treatment. Their primary drugs of choice were marijuana (32%), alcohol (27.5%), cocaine (14.9%), heroin (12.3%) and methamphetamines (3.9%). (Source: Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, FY 2004 Data Book. http://www.dhs.state.il.us/oasa/dasafy2004dataBook.pdf)

What percentage of referrals to addiction treatment are from the criminal justice system?

In 2002, 36% of admissions (655,000 admissions) to addiction treatment in the United States were from the criminal justice system. More than half (54%) of adolescent admissions to treatment were referred by the criminal justice system (compared with 40% in 1992). (Source: http://www.drugabusestatistics.samhsa.gov/2k4/youthTX/youthTX.cfm)

The criminal justice system is the largest source of referrals to addiction treatment. The types of criminal justice referrals are illustrated in Figure 1.

Figure 1. Criminal Justice System Referrals, by Type: 2002



(Source: 2002 SAMHSA Treatment Episode Data Set (TEDS) http://www.oas.samhsa.gov/2k4/CJreferrals/CJreferrals.htm)

In Illinois, 38% of clients entering treatment were criminal justice referred in FY 2004 with an additional 4% coming from TASC and 4% coming from DUI evaluators. Of the CJ referred clients, 75% came from Court Service referrals, 16% from DOC referrals, 5% from law enforcement and 4% from attorneys.

(Source: Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, FY 2004 Data Book. http://www.dhs.state.il.us/oasa/dasafy2004dataBook.pdf)

What percentage of people with AOD problems resolve these problems without professional treatment or recovery mutual aid involvement?

Many people with AOD problems (including many of those who meet DSM-IV criteria for substance abuse or substance dependence) resolve these problems without professional assistance or involvement in mutual aid groups such as Alcoholics Anonymous. In the scientific literature on addiction, this is referred to as natural recovery, spontaneous remission, or maturing out. Natural recovery is, according to some studies, the most common recovery pathway (Fillmore, Hartka, Johnstone, Speiglman & Temple, 1988; Sobell, Sobell, Toneatto, & Leo, 1993; Cunningham, Sobell, Sobell & Kapur, 1995; Cunningham, 1999; Sobell, Cunningham, & Sobell, 1996; Tuchfeld, 1981). Only a small portion (less than 25 percent) of those who recover from a substance use disorder do so through the vehicle of professionally-directed treatment (Knupfer, 1972; Vaillant, 1979; Sobell, et al., 1996). Natural recovery is most common in individuals with shorter and less severe AOD-using careers and those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell et al., 1996; Larimer & Kilmer, 2000). Natural recovery has also been documented across a wide variety of abuse and dependence patterns (opiate addiction, cannabis dependence, etc.)(Biernacki, 1986, Granfield and Cloud, 1999; Ellingstad, Sobell, Sobell, et al, 2005).

People who achieve a period of natural recovery are more prone to relapse than those who enter recovery through the mechanism of professional treatment, suggesting the need for monitoring and early re-intervention with both groups (Moos & Moos, 2006)

What distinguishes those who can and can't resolve these problems on their own?

Those who require treatment and/or sustained mutual aid involvement are distinguished by greater personal vulnerability (family history of substance-related problems, lowered age of onset), greater problem severity and chronicity, co-occuring medical and psychiatric disorders, and lower "recovery capital" (internal and external resources that can help initiate and sustain sobriety) (Room, 1989; Weisner, 1993; Bischof, et al., 2000; Granfield & Cloud, 1996, 1999; Tucker & Gladsjo, 1993). In the presence of these factors, individuals may need significant and ongoing support to initiate and sustain recovery. The operating principle seems to be: the greater the level of problem severity, the greater the likelihood an offender will need professional treatment and mutual aid resources to achieve recovery and reduce the likelihood of criminal recidivism as well as his or her threat to public safety.

One predictor of growing note is that of early age of onset of regular substance use. In the past four decades, substance experimentation has moved from a symbolic rite of passage from late adolescence into adulthood to a rite of passage from childhood into adolescence (White, 1999; Dennis, Babor, Roebuck, & Donaldson, 2002). This lowered age of onset of drug exposure is particularly pronounced in populations of adolescents and young adults entering the criminal justice system and addiction treatment programs. Thirty-eight percent of drug-using youth incarcerated within state-operated juvenile facilities reported onset of drug use before age 12 (19 percent before age 10) (U.S. Department of Justice, 1994). In the just-completed Cannabis Youth Treatment Study, more than 80 percent of the 600 youth admitted to the study began regular substance use between the ages of 12 and 14 (Dennis, Titus, et al., 2002). This trend has profound implications as lowered age of onset (before age 15) of AOD use has been linked to increased risks of adult substance use disorders, faster development of AOD problems, greater problem severity, co-occurring physical and psychiatric disorders, and poor intervention outcomes (White, Godley, & Dennis, 2003). Lowered age of onset of drinking has also been linked to increased lifetime risk of drinking and driving, and involvement in motor vehicle crashes while under the influence of alcohol (Hingson, Heeren, Jananka, & Howland, 2000).

Addiction Treatment

Who provides addiction treatment in the United States?

A 2003 survey of specialized addiction treatment facilities in the United States identified 13,626 such facilities that on March 31, 2003 had a total of 1,092,546 clients enrolled in treatment. More than 60% of the facilities surveyed in 2003 were operated by private non-profit entities, one-quarter were operated by private for-profit organizations, and the remainder were operated by Federal, State, local, or tribal governments. 80% of the facilities provided outpatient care, 28% provided residential treatment, and 7% offered hospital inpatient care. (Source: http://oas.samhsa.gov/2k5/nssats/nssats.cfm)

What are the major obstacles to people receiving treatment for an alcohol or other drug problem?

There are five major obstacles to entry into treatment: 1) the individual's own lack of desire to change or ambivalence about stopping AOD use, 2) geographical accessibility to the kind of treatment that is needed, 3) the lack of needed ancillary support services such as sober housing, transportation and day care, 3) the potential of waiting lists that preclude immediate admission to treatment and 4) the lack of financial resources to pay for treatment (White, 1998).

What can the criminal justice system do to facilitate treatment entry and support individuals who are on a waiting list to get into treatment?

Such efforts are important given research confirming that those on the waiting list are ambivalent about treatment, continue to use while on a waiting list, and often fail to enter treatment when the immediate crisis passes. (Graham, Brett & Bois, 1995). Drop-out rates for those on waiting lists to enter treatment range from 25-50% (Stark, Campbell, & Brinkerhoff, 1990). Criminal justice personnel can 1) maintain contact with and continually re-motivate those on waiting lists to enter treatment, 2) arrange interim recovery initiation resources (e.g., sober housing, linkage to recovery mutual aid groups), 3) provide recovery literature to those waiting to enter treatment, 4) conduct pre-treatment orientation and readiness groups, and 4) serve as an advocate with the treatment agency to speed admission to treatment.

Waiting lists are longest in most areas for residential treatment and methadone maintenance treatment. Probation officers may find individuals on prolonged waiting lists to enter residential treatment that, through enmeshment in sober housing and mutual aid groups and probation monitoring and support, initiate what by all appearances is a stable pattern of recovery. Waiting lists can serve as a filter for treatment need. Those who can initiate and sustain recovery for 60-90 days while on the waiting list may not need a residential level of care to achieve recovery.

What occurs in the assessment process?

The assessment process varies by treatment modality and across public and private sector settings but generally involves a determination of the type, severity and duration of AOD problems (via a physical, laboratory tests, and AOD use history); the identification of co-occurring medical, psychiatric, legal and occupational/educational problems as well as an evaluation of the family, social, occupational environment in which recovery will be attempted. This data is then integrated into a preliminary treatment plan that is refined over time in collaboration with each client and family.

What are the major types of treatment for substance use disorders?

There are many ways to classify treatment services. Treatment programs vary by:

- intensity of treatment, e.g., outpatient, intensive outpatient, residential
- the setting in which treatment occurs, e.g., with the client living at home, with the client living in a treatment community, or in jail or prison
- treatment philosophies (from biological, psychological, cultural and spiritual models), service delivery frameworks (individual, group, family) and particular techniques (from medications to interventions such as coping skills training, motivational enhancement, contingency management, 12-step facilitation, community reinforcement approach, relapse prevention, multidimensional family therapy)
- the duration of treatment services, e.g. brief intervention, short-term (less than 30 days) and long-term (more than 30 days)

The American Society of Addiction Medicine has defined placement criteria across five levels of care in addiction treatment: Level 0.5, Early Intervention; Level I, Outpatient Treatment; Level II, Intensive Outpatient/Partial Hospitalization; Level III, Residential/Inpatient Treatment; and Level IV, Medically-Managed Intensive Inpatient Treatment (ASAM, 1996). Admission criteria are defined for each level of care based on the following dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment. Addiction treatment exists on a continuum from high structure and intensity

(inpatient medical detoxification) to low structure and intensity (weekly outpatient counseling) and from brief interventions that span a few hours of professional contact to interventions that may last for years (methadone maintenance).

What factors determine whether someone gets residential or outpatient treatment?

Inpatient services are generally indicated for those individuals who present with:

- substance use disorders of great intensity and/or chronicity,
- acute medical/psychological problems that require close monitoring or care during detoxification and early recovery,
- a family/social environment that inhibits the initiation of sobriety, or
- a prior history of failure in outpatient addiction treatment modalities.

Is inpatient/residential treatment more effective than outpatient treatment?

It is hard to compare effectiveness across these levels because inpatient/residential treatment is used to treat the most severe substance use disorders. Both inpatient and outpatient treatment can be effective when matched to the right individual. A major problem of inpatient and residential programs is transfer of learning from the institutional environment to the client's natural environment. Where these environments are not conducive to sustained recovery, efforts must be made to alter these environments or to find alternative environments that can support recovery, e.g., recovery homes. Given the shortened lengths of residential treatment, efforts to evaluate these natural environments and the potential need for alternative environments must begin at the point of treatment admission.

Can't some individuals resolve AOD problems through very brief professional intervention?

There is a growing body of evidence that brief interventions can have very positive effects on those with alcohol problems (as measured by shifts to abstinence or moderated use), particularly among those with lower problem severity and greater natural resources (Brief Interventions, 2003). Brief interventions rely on feedback of personal risk, emphasizing the individual's personal responsibility and choice to resolve the problem, explicit advice to decelerate or stop AOD use, outlining a menu of ways to reduce or stop drinking, an empathic counseling style, expressions of confidence in the client's ability to change, personal-goal setting, and on-going monitoring and encouragement (Miller and Sanchez, 1993).

What are the most commonly used medications in the treatment of substance use disorders?

There are a growing number of pharmacological adjuncts in the treatment of addiction (most aimed at treating alcohol or opiate dependence) (Volpicelli, 2001; Senay, 1998).

1. Aids in detoxification, for example, benzodiazepines (e.g., valium) facilitate the safe elimination of substances from the body.
2. Stabilization agents such as methadone, levo-alpha-acetyl methadol (LAAM), and buprenorphine, enhance metabolic stability, reduce post-detoxification cravings and reduce relapse.
3. Aversive agents, such as Antabuse (disulfram), provide a chemical shield against impulses to use by eliciting toxic reactions (e.g., flushing, nausea/vomiting, increased heart rate) to even a small intake of alcohol.
4. Neutralizing agents (antagonists), such as naltrexone when used in the treatment of opiate addiction, neuter the ability of a drug to induce its desired euphoric effects.

5. Anti-craving agents, such as naltrexone, nalmefene and acamprosate used in the treatment of alcoholism, reduce post-withdrawal cravings for alcohol and reduce the rewarding effects of alcohol if it is consumed.
6. Agents such as antidepressants, mood stabilizers and neuroleptic (anti-psychotic) medications, used to treat co-occurring psychiatric disorders, are also common in addiction treatment given the increasingly high co-occurrence of depression, bi-polar disorder, anxiety disorder, and psychosis.

A recent trend has been the use of medications in combination (e.g., naltrexone and acamprosate in the treatment of alcohol dependence) (Johnson, 2000).

Medications will play an increasing role in the treatment of substance use disorders as new medications are developed that have fewer side effects and, as a result, generate higher rates of compliance related to their use (Alcohol Alert, 2000).

What are the major side effects of these medications?

Some of the medications used in addiction treatment are contraindicated for some offenders due to their medical or psychiatric status and several of these medications can have unpleasant side effects in a small percentage of individuals. Most of these side effects are transient and relatively mild. The most common of these side effects (constipation, nausea, dizziness, sedation, sweating, skin rash. headache, and fatigue) dissipate naturally or with adjustments in dosage, but some (such as impotence or delayed ejaculation) can compromise compliance.

Since some of these symptoms can surface after primary treatment is completed, it is recommended that probation officers monitor medication compliance, ask specific questions about any unpleasant side effects and encourage offenders experiencing such effects to report them to their physicians so that dosages may be adjusted or alternative medications prescribed.

There is considerable stigma and misinformation that continues to surround the use of methadone, particularly in the criminal justice system. Will this change with the growing emphasis on evidence-based practices?

No addiction treatment modality has been more extensively and rigorously evaluated than methadone maintenance treatment (MMT). Nearly every major health policy body has reviewed the evidence on MMT, including the National Institute on Drug Abuse, American Medical Association, American Society of Addiction Medicine, Institute of Medicine, National Academy of Sciences, National Institute on Health Consensus Panel, and the Office of National Drug Control Policy. These collective reviews conclude that orally administered methadone can be provided for a prolonged period at stable dosages (without the escalation in tolerance seen with morphine or heroin), with a high degree of long-term safety, and without significant effects on psychomotor or cognitive functioning. These reviews also confirm that MMT delivered at optimal dosages by competent practitioners: 1) decreases the death rate of opiate-dependent individuals by as much as 50%, 2) reduces transmission of HIV, hepatitis B and C and other infections, 3) eliminates or reduces illicit opiate use (by minimizing narcotic craving and blocking the euphoric effects of other narcotics), 4) reduces criminal activity, 5) enhances productive behavior via employment and academic/vocational functioning, 6) improves global health and social functioning, and 7) is cost-effective (White and Coon, 2003; National Consensus, 1998: Kreek and Vocci, 2002).

The positive effects of MMT documented in the literature are not automatic. They are contingent upon access to MMT, adequate dosages of methadone, competent staff, and a full range of psychosocial rehabilitation services. They are also contingent upon continued involvement in MMT. Rates of relapse following termination of MMT are high even for clients clinically judged to have a good prognosis for recovery without methadone. The effectiveness of methadone as a biologically normalizing agent and its prolonged utility in preventing relapse has prompted addictionologist Dr.

Avram Goldstein (2001) to compare the role of methadone in the treatment of the opiate-dependent person with the role of insulin in the treatment of the diabetic. Forty percent of individuals seeking treatment with heroin as their primary drug choice are placed in methadone treatment. (Source: http://www.drugabusestatistics.samhsa.gov/2k3/methadoneHtx/methadoneHtx.cfm) Today, approximately 179,000 of the more than 900,000 opiate addicts in the United States are enrolled in methadone maintenance treatment (Kreek and Vocci, 2002).

What pharmacological treatments are available to treat abuse or dependence on drugs other than alcohol or opiates (e.g., sedatives, cocaine, methamphetamine, hallucinogens, inhalants, cannabis)?

While there are medications used to treat acute adverse reactions to these substances and aid in detoxification (e.g., benzodiazepines), there are no specific medicines to treat other substance use disorders that are analogous to the roles methadone or naltrexone play in the treatment of opiate and alcohol addiction. The Food and Drug Administration has not yet approved any medications specifically for treatment of problems related to use of anabolic steroids, inhalants, hallucinogens, methamphetamines and other stimulants, or marijuana. There are, however, numerous funded studies seeking to find pharmacological adjuncts to help in the treatment of individuals experiencing problems related to these other substances. (Source: http://nida.nih.gov/Infofacts/treatmed.html)

There is a growing trend to concurrently treat those individuals entering treatment who are also addicted to nicotine. There are a variety of pharmacological treatments (gum, patches, nasal sprays) and medications such as bupropion used to treat nicotine addiction.

How long does treatment usually last?

The length of involvement in treatment varies by modality and by individual, with the longest lengths of stay usually reserved for those with very severe, complex problems and few recovery supports in their natural environment. A study of treatment discharges in the year 2000 revealed the following median lengths of stay across the country: Detoxification—5 days, outpatient treatment-91 days, intensive outpatient treatment—44 days, short-term residential rehabilitation—27 days, long-term residential rehabilitation—75 days,and hospital-based residential treatment 12 days. (Source: http://wwwdasis.samhsa.gov/teds00/TEDS_2K_CH6.htm)

Unfortunately, lengths of stay are often determined not by clinical need, but by administrative (intensity of demand for services via waiting lists) and fiscal (length of stay restrictions by payors) issues.

What are the characteristics of the most successful treatment programs?

There are several benchmarks that indicate a baseline of quality and professionalism in the provision of addiction treatment services. Some of the most significant of these include:

- state licensure,
- Accreditation by the Joint Commission on Accreditation of Health Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF),
- medical/psychiatric services or linkage arrangements,
- multidisciplinary staff; direct service staff certified as addiction counselors; supervising staff trained at M.A. to Ph.D. level,
- prior experience with drug choice, age, ethnicity, clinical profile of client being referred,
- use of global assessment instruments and processes,
- diversity of treatment modalities (full continuum of care),
- intensity of family involvement,

- intensity of linkage to mutual aid groups and other recovery support services,
- intensity and duration of aftercare programs; presence and strength of alumni association, and
- specialized services for clients with special needs, e.g., adolescents, women, clients of color, dually diagnosed, relapsed clients.

Methadone maintenance treatment programs that provide higher dosages of methadone (above 60 mg per day) and provide a broader range of psychosocial support services have better retention and long-term recovery rates than clinics that utilize lower doses and offer minimal ancillary support services. (Source: http://nida.nih.gov/Infofacts/TreatMeth.html)

Programs that have the best outcomes treating adolescent substance use disorders:

- use comprehensive assessment processes,
- focus on the special developmental needs of adolescents (family and group-oriented treatment),
- address co-occurring emotional/behavioral problems,
- provide strong programming in classroom academics and vocational counseling,
- have flexible policies regarding rule violations, and
- have well-organized monitoring and recovery support services that continue after initial treatment (Friedman & Glickman, 1986; White, Dennis, & Tims, 2002; Williams & Chang, 2000).

Seen as a whole, the treatment programs that are most effective offer a comprehensive range of services, provide ancillary services that address issues that may contribute to or result from prolonged substance use and which provide case management or recovery support services that address obstacles to treatment completion and recovery maintenance (Siegal, Rapp, Li, et al, 1997; McLellan, Grisson, Zanis, Randall, Brill & O'Brien, 1997; McLellan, Hagan, Levine, et al, 1999).

What does treatment cost, and who pays for this treatment?

Costs for addiction treatment vary from private to public sector programs, across modality and from provider to provider. The National Treatment Improvement Evaluation Study (NTIES), a Congressionally-mandated five-year study of the impact of drug and alcohol treatment, found that treatment costs in publicly funded programs range from a low of about $1,800 per client to a high of approximately $6,800 per client. The following differences in cost by modality were reported.



Comparative Cost of Treatment

Table 6. Type, Length and Cost of Treatment

Methadone	$13/day	$3,900/client (about 300 days)
Outpatient nonmethadone	$15/day	$1,800/client (about 120 days)
Correctional	$24/day	$1,800/client (about 75 days)
Long-term residential	$49/day	$6,800/client (about 140 days)
Short-term residential	$130/day	$4,000/client (about 30 days)

(Source: http://www.ncjrs.org/nties97/costs.htm)

Looking at the costs of treatment as a whole, 64% of these costs were publicly subsidized via federal/state funding (Medicaid, Medicare, Substance Abuse Prevention and Treatment Block Grants, and other federal/state funding), with the remaining 36% being paid for by private insurers, private

philanthropy or paid for by the clients and their families. (Source: http://alcoholism.about.com/library/weekly/aa00721a.htm)

What percentage of people admitted to addiction treatment in the United States do not successfully complete that treatment?

More than half of clients admitted to addiction treatment do not successfully complete treatment (24% leave against staff advice; 18% are administratively discharged for various infractions; 9% are transferred) (SAMHSA-OAS, 2002; Stark, 1992). Completion rates vary by modality: short-term residential treatment (61%); inpatient hospital treatment (55%); detoxification (51%), intensive outpatient treatment (42%), outpatient treatment (35%), long-term residential treatment (33%) and methadone treatment (15%), and are lower for drugs other than alcohol, particularly for opiates and cocaine (SAMHSA-OAS, 2002).

In Illinois, 56% of clients admitted to treatment in FY 2004 failed to successfully complete treatment, and 59% of CJ-referred clients failed to complete treatment.
(Source: Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, FY 2004 Data Book. http://www.dhs.state.il.us/oasa/dasafy2004dataBook.pdf)

How effective are current treatments for substance use disorders?

Seen as a whole, the overall effects of treatment are positive. Treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third, substance use decreases by an average of 87% following treatment, and substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). Recent studies confirm that addiction treatment outcomes are comparable to treatment outcomes for other chronic health conditions (e.g., Type I diabetes, hypertension and asthma) (McLellan, O'Brien, Lewis, & Kleber, 2000). The recognition of such overall positive effects has been linked to the willingness of probation officers to link offenders to treatment services (Polcin & Greenfield, 2003).

One of the largest and best-designed treatment outcome studies was Project Match, which tested the relative effectiveness of three models of treatment for alcohol problems (motivational enhancement therapy, cognitive-behavioral therapy, and twelve-step facilitation therapy). Drinking days among those treated declined from 75% of days to 20% of days following treatment, with the three models proving equally effective with approximately 50% of those treated (Project MATCH Research Group, 1998). This study also confirmed differences in outcome by problem severity. Those participants with the most severe alcohol problems did better (measured in days of abstinence) in 12-step facilitation therapy, and those with less severe problems did better in cognitive-behavioral therapy (Fuller & Hiller-Sturmhofel, 1999). Another large study in the Veterans Hospitals found very similar outcomes, with those in 12-step oriented programs more likely to have achieved continuous abstinence than those in cognitive behavioral programs (Ouimette, Finney & Moos, 1997).

Follow-up studies reveal highly variable responses to addiction treatment, including those who:

- remain continually abstinent following treatment (sustained abstinence effect),
- remain continually abstinent and function at levels superior to those preceding onset of substance use disorder (amplified effect),
- immediately return to pre-treatment levels of substance use (no effect),
- decrease their use to subclinical levels (moderated effect) or experience less severe problems than before treatment (partial effect),
- abstain initially but return to pre-treatment levels of substance use (transient effect),
- relapse following treatment but migrate to a pattern of stable recovery (delayed effect),
- recycling between periods of recovery and periods of relapse (ambivalent effect), and
- accelerate substance use following treatment (iatrogenic effect).

The most striking (and sobering) aspects of treatment outcome studies include the following findings:

- *Post-treatment Relapse:* The majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2002). Of those who consume alcohol and other drugs following discharge from addiction treatment, 50-60% do so within 30 days of discharge and 80% within 90 days of discharge (Hubbard, Flynn, Craddock & Fletcher, 2001).
- *Re-admission:* Between 25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year, 50% within 2-5 years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989; Simpson, Joe, & Broome, 2002). Of all those admitted to publicly funded addiction treatment in the U.S., 60% already have one or more prior treatment admissions (24% have three or more prior admissions) (SAMHSA-OAS, 2001). Those with five or more admissions were more likely to be homeless and unemployed (Source: http://drugabusestatistics.samhsa.gov/2K2/reasmitTX/readmitTX.cfm). In Illinois, 60% of all clients admitted to treatment in FY 2004 had one or more prior treatment episodes, and 12% of this group had four or more prior treatment episodes; 59% of criminal justice referred clients had one or more prior treatment episodes, and 5% had 4 or more prior treatment episodes (Source: Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, FY 2004 Data Book. http://www.dhs.state.il.us/oasa/dasafy2004dataBook.pdf).
- *Mortality:* Long-term follow-up studies of treated clients reveal a high mortality rate related to accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide and homicide (Hser, et al., 2001).
- *Addiction/Treatment Careers:* More than half of persons treated for substance dependence who achieve a year of stable recovery do so after 3-4 episodes of treatment over a span of eight years (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Hristova, 2002). These early years are often marked by cycling in and out of recovery initiation experiments prior to achieving recovery stability (Scott, Foss & Dennis, 2005). This suggests a positive cumulative effect of multiple treatment episodes for those with severe and complex substance use disorders. Another important finding is that the earlier the intervention (in terms of age and months/years of use) with a substance use disorder, the better the clinical outcomes and the shorter the addiction/treatment career (White & Dennis, 2002).

These stark findings do not mean that addiction treatment has no value. Treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third, substance use decreases by an average of 87% following treatment, and substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). Such findings suggest a wide range of positive effects that stand between immediate, complete and enduring abstinence on the one hand and unabated addiction on the other.

What are the specific effects of addiction treatment on criminal behavior?

The two treatments whose effects on criminal behavior have been most studied are therapeutic communities (TCs) and methadone maintenance treatment (MMT). These studies conclude that TC-based treatment reduces criminal behavior by 40 % or more and that MMT-based treatment reduces criminal behavior by as much as 50%.
(Source: http://www.nida.nih.gov/PODAT/PODAT5.html). A just completed 5-year follow-up study of the effects of addiction treatment on criminal recidivism confirm earlier studies that treatment generates significant reductions in criminal behavior the year following treatment and that criminal behavior continues to decline in the five years following treatment (Gossop, Trakada, Stewart & Witton, 2005; see also Hubbard, et al, 1997 & Simpson, et al, 2002).

What is the effect of addiction treatment on broader areas of personal health and social functioning?

Evaluations of addiction treatment consistently report post-treatment increases in employment and income, improvements in mental and physical health, decreases in criminal activity, decreases in homelessness and decreases in behaviors that put one at risk for HIV/AIDS infections. (Source: http://www.ncjrs.org/nties97/concl.htm)(http://www.whitehousedrugpolicy.gov/treat/effectiveness.html)

Do these outcomes differ for adolescents?

Adolescent treatment can be measured in terms of several potential post-treatment outcomes: abstinence, reduced frequency and intensity of drug use, reduced alcohol- and other drug-related problems, and changes in personal health, personal achievement (academic/vocational performance) and interpersonal relationships. The major reviews of adolescent treatment research have drawn the following conclusions.

All studies report significant reductions in the frequency and intensity of alcohol and other drug use following treatment (Titus & Godley, 1999). Most studies also report significant reductions in related problems (psychological adjustment, school performance, family relationships, criminality) following treatment (Hser et al, 2001). Treatment is superior to no treatment even when abstinence is not achieved, with post-treatment drug use reductions of around 50% of pre-treatment levels among those adolescents who use following treatment (Williams & Chang, 2000).

A review of studies that monitored adolescents following treatment found an average abstinence rate of 38% at one year following treatment, with different programs varying in abstinence rates. The rate of sustained abstinence after one year following residential treatment was 14-47% (data was from four studies). Adolescent outpatient rates of sustained abstinence are even lower. Only a minority of outpatients achieve abstinence at the time they are discharged from treatment. (Williams & Chang, 2000).

Post-treatment relapse rates for adolescents are high and can fluctuate over time. Relapse rates following treatment can be reduced for adolescents by providing post-treatment monitoring, support, and if necessary, early re-intervention (Brown et al., 2001; Godley et al., 2002).

Are there any science-based principles to guide the delivery of addiction treatment and the expectations of what a single episode of treatment can achieve?

The National Institute on Drug Abuse recently released the following thirteen research-based principles of effective addiction treatment:

1. *No single treatment is appropriate for all individuals.*
2. *Treatment needs to be readily available.*
3. *Effective treatment attends to multiple needs of the individual, not just his or her drug use.*
4. *An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.*
5. *Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment.*
6. *Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.*
7. *Medications (methadone, naltrexone) are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.*

8. *Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.*
9. *Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.*
10. *Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.*
11. *Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment.*
12. *Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.*
13. *Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.*

(Source: http://www.nida.hih.gov/PODAT/PODAT1.html)

How important is participation in post-treatment continuing care (what in some places is called "aftercare") to long-term recovery outcomes?

Participation in continuing care following primary treatment is associated with improved outcomes at follow-up (Ito & Donovan, 1986; Johnson & Herringer, 1993; Godley, Godley, & Dennis, 2001; Dennis, Scott, & Funk, 2003), but only 1 in 5 adult clients receive continuing care services following discharge from addiction treatment (McKay, 2001), and only 36% of adolescents receive any continued care contact following discharge from addiction treatment (Godley, Godley & Dennis, 2001). The figures underscore the importance of post-treatment monitoring via probation and court services of those individuals under the supervision of the criminal justice system.

How can post-treatment monitoring and support be improved?

The first point of enhancement involves the process of linking clients to recovery mutual aid societies while they are in treatment. Active linkage (facilitating direct connection to a person or specific group) can increase affiliation with a recovery mutual aid society (Weiss, et al 2000), but studies reveal most referrals to mutual aid are of the passive variety (verbal suggestion only) (Humphreys, et al 2004). Improving such linkage through the treatment center site or by probation officers would mark a significant improvement.

There are also new approaches to assertive continuing care being pioneered that place a greater emphasis on post-treatment monitoring and recovery support services. A recent study tested the effects of proactive, quarterly recovery management checkups, early re-intervention and treatment re-linkage on 448 clients (predominately African American women dependent upon cocaine, opiates and alcohol) entering treatment via a central intake unit in Chicago (Dennis, Scott, & Funk, 2003). Following their primary treatment, the clients were randomly assigned to receive the recovery management checkup (RMC) protocol or a quarterly follow-up interview for data collection, but no services. Follow-up data was collected from participants on a quarterly basis over the 24 months following their discharge from treatment. Compared to the control group, at 24 months those clients receiving RMCs and early re-intervention services 1) used substances on fewer days following treatment, 2) were more

likely to return to treatment, 3) returned to treatment sooner, 4) stayed in treatment longer when they returned, and 5) experienced fewer quarters over the two years in which they were in need of treatment services.

These new approaches, variably referred to as recovery management (RM) or assertive continuing care (ACC), differ from traditional aftercare services in four significant ways:

1. RM/ACC shifts the responsibility for post-treatment contact from the client to the service professional.
2. RM/ACC capitalizes on critical windows of vulnerability following treatment, particularly the first 90 days (studies reveal that 80% of all people who relapse following treatment do so in the first 90 days.).
3. RM/ACC individualizes the monitoring schedule based on clinically relevant points of vulnerability that can be predicted by the client.
4. RM/ACC emphasizes continuity of contact in a primary recovery support relationship over time.

In the traditional model, clients who relapse following treatment do not return to treatment until the severity of their problems have returned to high severity and their family and social supports have again eroded. In the RM/ACC model, clients are re-linked to treatment at a lower level of problem severity and a higher level of family and social support—conditions that enhance the prognosis for long-term recovery following treatment. Where local treatment programs do not provide RM/ACC-type post-treatment support services, criminal justice professionals, particularly probation officers, could play an important role in post-treatment monitoring and recovery support.

Recovery

What is recovery and how is it different from treatment?

R*ecovery* is the process through which severe and persistent alcohol and other drug (AOD) problems (those problems meeting DSM-IV criteria for *substance abuse* or *substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health (White & Kurtz, 2005). Treatment is a professional intervention that focuses on solidifying motivation for recovery initiation and achieving early biopsychosocial stabilization. In contrast, recovery is the long-term process of sustaining and enhancing that motivation and stability.

What is the prevalence of recovery from substance abuse and substance dependence?

There is no system of regularly collecting data on the prevalence of recovery in the U.S. that is comparable to the national surveys that measure changes in prevalence and patterns of alcohol and other drug use. Data that is available comes from three sources: 1) follow-up studies of individuals treated for a substance use disorder, 2) occasional community-wide surveys and 3) membership surveys of recovery mutual aid organizations. The follow-up studies and community surveys of the past 25 years reveal significant recovery rates: 41% (Ojesjo, 1981), 63% (Helzer, Burnam, & McEvoy, 1991), 72% (Dawson, 1996), 30% (Schutte, Nichols, Brennan, & Moos, 2001), 59% (Valliant, 2003), and 48% (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Variations in reported recovery rates are influenced by such factors as different demographic and clinical characteristics of study participants and different definitions of recovery.

One indication of the extent of recovery comes from studies that compare lifetime prevalence of alcohol abuse and dependence to past year alcohol abuse and dependence. In one recent study, 13% of adults in America reported meeting criteria for alcohol abuse or dependence during their lifetime, but past year prevalence of alcohol abuse and dependence was only between 4 and 5% (Grant, 1997).

The difference in these percentages suggests a large population of Americans who have resolved, are resolving or will resolve AOD problems.

Are there degrees of recovery?

The resolution of substance use disorders, like other chronic health problems range from:

- *full recovery:* complete and enduring cessation of all AOD-related problems and the movement toward global health,
- *partial recovery:* reduced frequency, duration, intensity and consequences of AOD use in tandem with increases in personal functioning (Jorquez, 1983; Hser, Hoffman, Grella, & Anglin, 2001), and
- *enriched recovery*: individuals who through recovery get "better than well"—experience changes so profound that they bring great depths of experience, meaning and social contribution (White & Kurtz, 2005)

Treatment outcome studies have documented the first of these patterns and the third pattern is often heard referenced in various recovery mutual aid meetings. A recent analysis of treatment outcome studies drew three major conclusions: 1) treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third of those treated, 2) substance use (measured by days of use and volume of use) decreases by an average of 87% following treatment, and 3) substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). It is clear from such findings that people who are constitutionally incapable of permanent sobriety may achieve *partial recovery*-significant decreases in AOD-related problems, improved levels of health and social functioning, and significant reductions in the social costs and threats they pose to the larger community (Zweben 1996).

Are there different styles of recovery?

Recovery can reflect a process of sudden transformation or a process of incremental change. Most people resolve severe and persistent AOD problems through multiple efforts–self-resolutions, mutual aid support and professionally directed treatment–spanning an extended period of time before final resolution is achieved (Vaillant & Milofsky, 1982). But there are individuals (as many as one-third in surveys of recovered people) whose abstinence decision occurred "immediately" rather than incrementally (Sobell, et al., 1993; Burman, 1997). Miller and C'de Baca (2001) found that this type of "quantum change" or "transformative change" is usually marked by high vividness (intensity), suddenness (unintentional), positiveness and permanence of effects. Some of these "spontaneous" recoveries reflect quite extraordinary conversion-like experiences, while others represented a seemingly insignificant experience that was the proverbial "straw that broke the camel's back." It is clear that the priming dose of negative consequences and hope-infusing experiences necessary to ignite recovery can come climactically or incrementally.

There are religious, spiritual and secular frameworks of recovery. *Religious and spiritual frameworks* of recovery involve experiences of connection with resources within and beyond the self and involve a reconstruction of personal identity and interpersonal relationships (e.g., participation in a community of shared faith), and a reformulation of personal values (e.g., humility, gratitude, and forgiveness) (Kurtz & Ketcham, 1992). *Secular recovery* is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or rituals (prayer) (White & Kurtz, 2005).

There are also variations in recovery styles based on the degree to which people in recovery relate to others in recovery. There are acultural (recovery without contact with other recovering people), bicultural (recovery while relating both to people in recovery and people without recovery experiences) and culturally enmeshed (exclusive contact with others in recovery) styles of long-term recovery (White & Kurtz, 2005).

What are the typical stages of recovery from addiction?

Klingemann's (1991) three-stage recovery model (motivation, action, maintenance) and Prochaska and colleagues' (1992) six-stage recovery model (precontemplation, contemplation, planning, action, maintenance, and termination) underscore the fact that the process of recovery begins *before* AOD use is moderated or terminated. They further contend that while a single, linear movement through these stages is possible, the more common pattern is a spiral pattern of repeated movements through these stages before permanent recovery is achieved. Other studies of the stages of recovery (Frykholm, 1985; Biernacki, 1986; Waldorf, 1983; Brown, 1991) reinforce that this transformation involves these stages: ambivalence regarding use, consequences related to use, a turning point, sobriety sampling, confirmation of sobriety commitment, disengagement from the culture and rituals of use and sobriety consolidation.

White and Kurtz (2005) have described the transformation from addiction to recovery as escalating AOD-related pain (I need to recover), the desire to change (I want to recover), hope for the possibility of change (I can recover), commitment to change (I am going to recover), experiments in abstinence (I am recovering), and movement from sobriety experiments to sobriety identity (I am an ex-addict/recovered/recovering alcoholic/addict).

What percentage of clients experience one or more episodes of relapse before establishing permanent sobriety?

In a 2001 national household survey of people in recovery from addiction, 53% of those who self-identified themselves as in recovery reported that they had not experienced a relapse since committing themselves to recovery; 16% reported that they had experienced one relapse since beginning their recovery, and 30% reported having had more than one relapse. (Source: Highlights from the First-ever National Survey of the Recovery Community. www.facesandvoicesofrecovery.org) Such samples include many individuals with much lower levels of problem severity and much greater recovery support resources than are commonly seen in publicly funded addiction treatment or the criminal justice system. Lapses (short episodes of use following be re-initiation of recovery) and relapses (more sustained episodes of use and AOD-related problems) as a precursor to stable recovery are much more common in criminal justice offenders.

There are five patterns of post treatment outcome: 1) continuous sobriety, 2) continuous use during or following treatment, 3) early sobriety followed by clinical deterioration and full relapse, 4) early lapses or relapses following by a rebound into stable recovery, and 5) periodic cycling in and out of addiction and recovery. Group one requires continued praise and support, group two requires re-intervention with criminal justice sanctions and a more structured and intense level of treatment, and groups three, four and five require progressive sanctions, recovery support and early re-intervention. The integration of active relapse prevention planning within probation supervision can enhance long-term recovery outcomes.

What role do Alcoholics Anonymous and other recovery mutual aid groups play in the recovery process?

Most of what we know about recovery mutual aid societies is based on studies of Alcoholics Anonymous (A.A.). A.A. is the most widely used community resource in the United States for the resolution of alcohol-related problems. (Room, 1989; Room & Greenfield, 1993; Weisner, Greenfield, & Room, 1995). In a 1990 household survey, 3.1 percent of those interviewed reported having attended A.A. sometime in their life for an alcohol problem and, of those, 1.5 percent reported having attended A.A. in the past year—a figure that far exceeds A.A.'s report of its current membership (Room & Greenfield, 1993). Mutual aid involvement can play a significant role in the movement from addiction to recovery for both adults (Timko, et al., 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Timko, et

al, 1999; McCrady & Miller, 1993; Emrick, et al., 1993) and adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000).

The positive effect of mutual aid comes not from exposure alone (e.g., mandated A.A. attendance), but by what might be called an intensity effect. Recovery outcomes improve with the number of meetings attended in the first three years of recovery (Humphreys, Moos, & Cohen, 1997; Chappel, 1993). Other measures of intensity of involvement include active application of program concepts (e.g., "working the steps"), meeting participation (attendance, speaking, interacting, leading, having a home group), participation in pre- and post-meeting rituals, use of mutual aid networks for fellowship and leisure, reading program literature, being sponsored, sponsoring others and involvement in other service work (Cross, et al., 1990; Johnson & Herringer, 1993; Emrick, et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, & Cohen, 1997). This intensity effect of mutual aid involvement has been found to apply to adolescents as well as adults (Margolis, Kilpatrick, & Mooney, 2000).

The positive effects of recovery mutual aid involvement include the reconstruction of personal identity and values and the construction of a sobriety-based social network. Many substance-involved offenders enter the criminal justice system deeply enmeshed in a culture of addiction—in fact may be as dependent upon that culture as the drugs in their lives. Recovery mutual aid groups provide a means for detaching from the culture of addiction and enmeshing oneself in a culture of recovery (White, 1996).

Does this positive effect extend to those who undergo mandated exposure to AA via criminal justice coercion?

An exception to AA's effectiveness involves coerced involvement in A.A. through the criminal justice system. When coerced A.A. attendance is compared via randomized trials to alternative interventions, forced A.A. exposure generates worse long-term results (See Kownacki & Shadish, 1999 for a review). Such findings challenge the practice of coerced A.A. attendance as a condition of sentencing or probation regulations.

What percentage of A.A. members achieve long-term sobriety?

The latest survey of Alcoholics Anonymous reveals a membership of more than 2 million. The average length of reported continuous sobriety among A.A. members is eight years, with 36% of A.A. members reporting continued sobriety of more than ten years. About a quarter of A.A. members at any time are in early recovery (have less than a year of sobriety) (A.A. Grapevine, July, 2005).

Aren't A.A. and other Twelve Step groups less effective for special populations, e.g., women, ethnic minorities, etc.?

While the original membership of A.A. during its formative years (1935-1939) was almost exclusively white, middle-aged men, criticisms that A.A./N.A. and other 12-step groups are not appropriate for women, ethnic minorities, and other special populations have not held up under scientific investigation (Gilbert, 1991). Women and cultural minorities affiliate with A.A./N.A. at the same rates as white men (Humphreys, et al., 1994), and at least one report suggests women may have an easier time affiliating with 12-step groups than men (Denzin, 1987). Recent surveys of 12-step group participation reveal no racial differences in levels of affiliation or participation (Kessler, et al., 1997; Winzelberg & Humphreys, 1999). African Americans and Caucasians affiliate with AA at virtually the same rates, but African American participation declines at a greater level than Caucasians after the first year. (This may be related to African Americans, particularly African American women, migrating to a traditional Black church as their primary sobriety-based support structure. Population surveys have revealed that A.A. is widely known in minority communities and recommended as a resource for alcohol problems (Caetano, 1993). A.A. membership surveys reveal that 4.4% of A.A. members are Hispanic and 3.2%

of A.A. members are African American. Women currently constitute 35% of A.A. membership (Alcoholics Anonymous, 2005).

Specialized recovery mutual aid resources may enhance recovery for those who bring special obstacles or vulnerabilities to their attempts to initiate recovery (Laudet, et al., 2000). Double Trouble in Recovery (DTR) groups or professionally directed support groups may enhance recovery for the dually diagnosed who may not be comfortable or welcomed in regular A.A./N.A. meetings (Noordsy, et al., 1996). There is, however, recent survey evidence to suggest that individuals with comorbid psychiatric illness do affiliate with A.A. and that participation in A.A. is positively associated with stable recovery (Ouimette, et al., 2001).

The assumption that those with no or low religious orientation would not do well in 12-step programs—a practice that has led to decreased referrals of atheists and agnostics to A.A. (Winzelberg & Humphreys, 1999)—has been challenged by research revealing that those with low religious orientation affiliate with A.A. at rates similar to those with high religious orientation (Winzelberg & Humphreys, 1999) and, in some studies, do not seek out non-spiritually-based alternatives to A.A./N.A./C.A. even when available (Weiss, et al., 2000). In contrast to these findings, Tonigan, Miller, and Schermer (2002) found that atheists and agnostics were less likely to attend AA and more likely to disaffiliate from AA following initial exposure.

Kelly, Myers, and Brown (2002) conducted a study of 12-Step group affiliation among adolescents. They found that 71.6 percent of youth completing a Minnesota Model treatment program attended at least one 12-Step meeting in the first three months following treatment. It was concluded that affiliation and the positive effects from such affiliation were linked to youth with more severe AOD problems.

What about people who don't feel comfortable in A.A. or other 12-Step Groups?

There are a growing variety of adjuncts and alternatives to 12-Step recovery groups in the United States. These include religious frameworks (Alcoholics Victorious, Mountain Movers, Alcoholics for Christ, various recovery ministries), secular frameworks (Secular Organization for Sobriety, LifeRing Secular Recovery), gender-specific support (Women for Sobriety), culturally nuanced frameworks (the Red Road, Free N' One) and moderated recovery frameworks (Moderation Management) of problem resolution. A guide to these mutual aid resources that is updated each month is posted at http://facesandvoicesofrecovery.org/resources/support_home.php.

Are there support services or special support meetings for particular occupational groups?

Yes. Most of these are for professions that would face special stigma if it were known that they had an alcohol or other drug problem. These groups include the Impaired Nurse Network (National Nurses Society on Addiction), Peer Assistance Network for Nurses (Illinois Nurses Association), Dentists Concerned for Dentists, Lawyers Assistance Program, Lawyers Concerned for Lawyers, International Lawyers in Alcoholics Anonymous, International Pharmacists Anonymous, Illinois State Medical Society Impaired Physician Program, and International Doctors in Alcoholics Anonymous.

What percentage of clients sustain mutual aid involvement following treatment?

Overall dropout rates in A.A. are reported to range between 35-68%, with most of this attrition occurring in the first weeks and months of contact with A.A. (Emrick, 1989). The two most recent and largest studies of persons who drop out of A.A. participation in the first year following treatment place such attrition at 41% and 40% (Tonigan, Miller, Chavez, Porter, Worth, Westphal Carroll, Repa, Martin & Tracy, 2002; Kelly and Moos, 2003).

What can the criminal justice system can do to increase mutual aid engagement and retention rates?

Research has confirmed that passive linkage (verbal encouragement) is much less effective than active linkage (assertive introduction to a particular person or group). The attrition rate noted above would indicate the need for pre-linkage orientation to A.A., personalized and matched referral to particular individuals and meetings, monitoring of continued attendance and response to A.A., and when indicated, active referral to alternatives to A.A. The ever-growing diversity of recovery support groups calls for matching individual clients to particular groups and meetings (and individual representatives of such groups/meetings) by such factors as age, gender, socioeconomic status, drug of choice, smoking status, and attitudes toward religion and spirituality (Forman, 2002; White & Nicolaus, 2005). Probation officers can enhance offender engagement in mutual aid groups by becoming personally knowledgeable of such groups (e.g., attending open meetings, meeting with representatives of Hospital and Institution Committees of AA/NA) and by linking each offender to a particular group or individual within the local recovery community. (For a monograph on how to professionally link individuals to recovery mutual aid groups, see White and Kurtz, 2006).

When is a pattern of sobriety stable and enduring?

The stability and durability of addiction recovery increases with length of continuous sobriety (Vaillant, 1983). A growing number of studies are suggesting that the point at which most recoveries become fully stabilized is between four and five years (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, et al., 1989; Dawson, 1996; and Jin, et al., 1998). While relapses can and sometimes do occur in those with five or more years of sobriety, the rate of relapse is low (below 15 percent) after the achievement of five years of stable recovery.

Recovery durability differs by drug choice. Studies of heroin addicts have confirmed the instability of periods of abstinence. Studies of recovered heroin addicts found that while five years of abstinence significantly reduced the risk of future relapse, the subsequent relapse rate was higher with heroin addiction than the rates reported for alcoholism (Maddux & Desmond, 1981; Hser, et al., 2001). Those at greatest risk of relapse following the achievement of five or more years of sobriety are those with the greatest characterological problems and adverse drinking-related social consequences (Jin, et al., 1998). Once attained, recovery is more durable for those with late onset alcohol problems compared to those with early onset alcohol problems (Schutte, et al., 1994).

The best indicators of recovery stability are time, reconstruction of personal identity (presence of a 3-part story style, e.g., my life before, what happened to change it, my life now), and reconstruction of one's social network.

Won't some offenders resolve their substance-related problems without permanent abstinence?

The ability to resolve alcohol problems through moderation rather than abstinence strategies is highly influenced by problem severity. As problem severity increases, the likelihood of a successful, sustained, and moderated resolution declines. A recent review (Larimer, et al., 1998) of the research on moderated outcomes for alcohol problems drew the following four conclusions:

1. Even in traditional abstinence-oriented treatment programs, some alcohol-dependent clients choose and achieve moderation goals.
2. Even when they are trained in controlled drinking, many alcohol-dependent individuals choose abstinence. Over time, rates of abstinence (as compared to controlled drinking) tend to increase.
3. Offering a choice of goals tends to result in greater treatment retention and recruitment of a broader range of problem drinkers, without increasing the risk of relapse to uncontrolled-drinking states.

4. Client characteristics, goal choice, and severity of dependence may all be related to treatment outcome (abstinence, moderation, or relapse); when given a choice, individuals tend to choose the goal that is most appropriate for them.

The fact that those who resolve alcohol problems through moderation differ from those who resolve such problems through abstinence is a crucial point further confirmed by studies of Moderation Management (MM). Klaw and Humphreys (2000) found that one-third of MM membership would not meet diagnostic criteria for an alcohol use disorder, and that of those who did, nearly all met the criteria for alcohol abuse rather than alcohol dependence. Given the earlier data presented on the level of problem severity among most DUI offenders, abstinence goals would seem most indicated for those offenders whose history indicates a significant problem with alcohol or other drugs. Individuals seeking reinstatement of driving privileges through the Secretary of State bear the burden of proof that their resolution goal (abstinence or moderation) is congruent with the intensity and duration of their drinking history/problems and that this resolution (abstinence or moderation) marks a sustainable pattern of stability rather than a brief, externally posed hiatus in their drinking career.

What is the effect of recovery on the family?

Severe AOD problems fundamentally alter family roles, rules and rituals in ways that help the family in the short run but harm family relationships and individual development in the long run. (For a detailed review, see White and Savage, 2003) In recovery, these maladjustments of the family have to collapse and then be radically reoriented. Brown & Lewis have described the demands of this process on the family as the "trauma of recovery" (Brown & Lewis, 1999). Recovery forces individual family members to work through the impact that addiction has had on each of their lives, reformulate all family relationships (adult intimate relationships, parent-child relationships, sibling relationships, relationships with extended family) and develop recovery-supportive relationships with broader social and kinship networks (White, 1996).

Family recovery is not an easy or rapid process. Aspects of this "unsafe, potentially out-of-control environment" continue for as long as three years into the initiation of sobriety and mastery of early recovery (Brown & Lewis, 1999). Families (particularly marriages/partnerships) that have survived every manner of insult addiction presented may not survive intact if professional and social supports are not available to soften the new demands that recovery imposes (Rouhbakhsh, Lewis, & Allen-Byrd, 2004). Similarly, recovery does not automatically bring effective parenting: "...children may be just as neglected and abandoned in recovery as they were during the drinking, or more so, as the system collapses and parents turn their attention away from the family onto themselves" (Brown and Lewis, 1999, p. 23). Women-focused recovery literature is replete with references to mothers in early recovery shifting from a pattern of rejection of children during addiction to a pattern of acceptance, but overprotection and overindulgence, in early recovery (Kirkpatrick, 1986). The recognition of these prolonged effects are prompting renewed calls for more family-oriented models of intervention and treatment.

Probation officers will also witness inexplicable efforts on the part of family members to sabotage an offender's early recovery efforts. The reasons for such sabotage are many and include the co-addiction of other family members, fear of intimate partners that the offender will leave if he or she gets sober, and fear of loss of income to the family from drug-related enterprises. Such possibilities call for a careful assessment of the family and social environment in which recovery initiation is being attempted. Where this environment is clearly toxic, structured sober living (e.g., recovery home) is clearly indicated.

What support services are available to assist families through the recovery process?

Family members can benefit from both professional and peer support (e.g., Al-Anon) during the sustained recovery process. Some treatment programs have services specifically designed for family

members, and family members can access peer-based supports either through local face-to-face or online family support groups.

Are there culturally specific pathways to recovery?

There are particular patterns of recovery that have been noted in the research literature. A report on African American women treated in Illinois through the 23 Project SAFE treatment sites notes the propensity for African American women in recovery to migrate from Alcoholics Anonymous or Narcotics Anonymous to involvement in their churches as their "primary sobriety-based support structure" in the months and years following treatment (White, Woll and Webber, 2002; see also Sanders, 2002; White & Sanders, 2004). Culturally prescribed frameworks of AOD problem resolution are evident in abstinence-based religious and cultural revitalization movements (e.g., Nation of Islam, the Red Road) as well as cultural adaptations of existing recovery support structures (e.g., the "Indianization" of Alcoholics Anonymous and the adaptation of A.A. within Hispanic/Latino communities) (Womak, 1996; Hoffman, 1994; Coyhis & White, 2006).

The Role of the Criminal Justice System in Addiction Recovery

What percentage of persons in the criminal justice system have significant problems with alcohol and/or other drugs?

Persons with significant AOD problems exert a tremendous impact on the criminal justice system. More than 1.5 million individuals are arrested every year for drug violations in the United States (Federal Bureau of Investigation, 2002). A study of AOD use at the time of arrest in 33 American cities found that 64% of all men and women arrested tested positive for drugs at the time of their arrest (National Institute of Justice, 2002). Twenty-nine percent of victims of violent crime report that their attacker was under the influence of alcohol and/or drugs at the time of the attack (U.S. Department of Justice, 2002).

Drug-related offenses consume significant resources from America's court systems, with drug offenses accounting for more than one third of all U.S. district court cases (U.S. Department of Justice, 2001). Drug offenders in state prison increased from 149,700 to more than 250,000 between 1990 and 2000, and more than 73,000 drug offenders currently reside in federal prisons (56% of federal offenders) (Federal Bureau of Prisons, 2002). Drug offenders make up 25% of those on probation in the United States and 33% of those released from prison (Office of National Drug Control Policy, 2003).

A recent study found that substance abuse and addiction are implicated in the incarceration of 80%-1.4 million-of the 1.7 million men and women currently incarcerated in the U.S. Between 1980 and 1995, individuals arrested for violation of drug laws accounted for 30% of the growth in state prison populations and 68% of the growth in the federal prison population. That same study reported that taxpayers spend $30 billion a year to incarcerate individuals with a history of AOD problems. (http://www.casacolumbia.org/absolutenm/templates/PressReleases.asp?articleid=167&aoneid=49) AOD problems also contribute to re-incarceration of offenders. Of the one-third of new admissions to prison each year resulting from parole violations, 16% of these are directly attributable to a drug-related violation (arrest on a drug-related charge or repeated positive urine screens) (Hughes, Wilson & Beck, 2001). Also noteworthy is the fact that the majority of people entering the criminal justice system with alcohol and other drug problems do not have prior treatment, making contact with the criminal justice system an ideal opportunity to initiate such services.

Between 1990 and 2002, the drug offense arrest rate more than doubled from 402 to 828 arrests per 100,000 population (Accessed September 3, 2005 at **http://www.icjia.state.il.us/public/index.cfm?metasection=Data&metapage=JTF_DrugArrests**). In Illinois, there were 11,292 adults and 181 juveniles incarcerated for drug offenses on June 30, 2004 (25% and 11% respectively of the total prison population.) These numbers do not reflect those who are incarcerated for other drug-related charges, i.e., burglary, theft, prostitution. Since 1994, the drug

offender population has grown 37.3%, with most of these offenders returning to the community after a relatively short period of incarceration. In 2003, 5,942 inmates were released following an average 4-5 month period of incarceration for possession of a controlled substance. The total population of persons released from prison on drug charges have a three-year recidivism (re-incarceration) rate of 53.3%. Incarcerations for DUI rose more than 500% between 1994 and 2003 (from 75 to 463).

(Source: Illinois Department of Corrections Statistical Presentation 2003 http://www.idoc.state.il.us/subsections/reports/statistical_presentation_2003/2003StatisticalPresentation.pdf)

What types of interventions for AOD problems are being provided inside the criminal justice system?

Under the initial influence of Project REFORM (funded by the Bureau of Justice Assistance of the U.S. Department of Justice), Project RECOVERY (funded by the Center for Substance Abuse Treatment) and the initiatives of the Department of Justice's Drug Courts Program Office, states have made significant progress in launching diversion programs, pretrial release programs (conditioned on entry into treatment), drug education programs, assessment and referral services, mandated treatment through specialized drug courts, specialized intensive probation services, in-prison treatment and pre-release and post-release counseling and referral programs (Lipton, 1995). These efforts are significant. In 2002, the criminal justice system referred 655,000 individuals to addiction treatment across the country and referred more than 77,000 individuals to treatment in Illinois (DASIS Report, 2004; FY2004 Data Book). More than 173,000 offenders are treated annually inside jails and prisons in the United States (SAMHSA, 2000). The Illinois Department of Corrections currently (September, 2005) has 3,685 beds within its prison designated for specialized addiction treatment, including the 900 bed facility at Sheridan exclusively devoted to addiction treatment. Of the total IDOC treatment beds, 506 are designated for women and 493 are designated for juveniles.

Providing supervision and support services for alcohol and other drug-related offenses also consumes considerable probation resources. A total of 14,825 adult probations in Illinois were ordered to participate in alcohol and drug programs as part of their probation during 2003. There were 13,743 DUI offenders on probation in 2003, 14.7% of the total probation caseload in Illinois. (Source: http://www.state.il.us/court/SupremeCourt/AnnualReport/2003/StatsSumm/pdf/cir_adult&juv.pdf)

What is the status of the drug court movement in the United States and in Illinois?

There are currently more than 1,100 drug courts operating in the country (Drug Courts Program Office, 1999), and 22 drug courts operating in Illinois. Many more are being planned as well as adaptations to the drug court model (e.g., mental health courts in Cook, Winnebego and Lake Counties). What distinguishes drug courts is the unique combination of judicial monitoring (regular status hearings), addiction treatment and case management services, drug testing, probation supervision, a non-adversarial collaboration between prosecution and defense counsel and multi-agency case conferences for service planning and progress review. (For comprehensive information regarding the components of drug courts, see *Defining Drug Courts: The Key Components*, Washington, DC: Office of Justice Programs, Drug Courts Program Office, 1997). While drug courts vary considerably, the most critical elements in the Illinois programs are strong judicial leadership (a committed judge), frequent status calls, a treatment provider that can work with relapse prone clients (rather than throwing them out of treatment), and a probation officer knowledgeable about recovery and committed to assertive monitoring, and, when needed, early re-intervention. The positive response to the pilot studies and now established drug courts is triggering adaptations of the adult drug court model. These adaptations include tribal drug courts, juvenile drug courts, mental health courts, family and dependency courts and DUI courts. One of the major deficiencies of drug courts is the lack of a model blueprint of progressive sanctions and awards linked to offender behavior.

How effective is treatment inside the criminal justice system?

Several aspects of treatment in the criminal justice system have been evaluated. In 2001, the National Center on Addiction and Substance Abuse at Columbia University completed the most recent critical review of drug court research and evaluation activities. The critical review of drug court research indicates:

- Drug use and criminal activity are reduced while participants are in drug court.
- Studies using comparison or matched samples show lower re-arrest rates for drug court participants than for the comparison group.
- A majority of the studies found lower post-program recidivism rates for drug court participants.
- For those drug courts conducting cost analysis, estimates indicate that drug courts are less expensive than traditional adjudication.

(Source: http://www.ncsconline.org/WC/FAQs/DrugCtFAQ.htm#Are drug courts effective.)

As close observers of the drug court movement around the country and in Illinois, the authors are struck by the highly variable service combinations that constitute what are being called drug courts. There seems to be no single drug court model in Illinois. We are also struck by how much the effectiveness of drug courts seems to be shaped by the commitment and style of the judges who found them. Our concern is the extent to which drug court effectiveness can be maintained when this generation of drug court pioneers move to other venues or retire and turn their drug courts over to individuals who may be less knowledgeable about and less committed to the model. We have also noticed a positive trend in Illinois of judges using more open probation orders, which allows the probation officer to establish case plans and then establish joint agreement on the plan between the judge, the probation officer and the offender.

A recent follow-up study of prison-based treatment in the state of Connecticut found that, while nearly 46 percent of Connecticut's prison population are rearrested within a year of release, only 37.4 percent of inmates who receive brief substance-focused treatment and only 23.5 percent of inmates who receive intensive treatment are rearrested in the year following their release. (Source: http://www.jointogether.org/sa/action/dt/news/reader/0,2812,575760,00.html). This study reflects two national research trends: 1) re-arrest and re-incarceration rates are lower for those drug involved offenders who go through treatment inside prison, 2) the degree of that effect is influenced by treatment dose and intensity, with those experiencing longer episodes of more intense treatment having the lowest recidivism rates.

Don't people have to have motivation to recover for treatment to work?

The view that motivation for recovery at the time of admission to treatment was an important predictor of long-term recovery outcomes has a long history in the addiction treatment field, but this view is not supported by the latest scientific research. A recent review of the literature on the effectiveness of coerced treatment concluded that retention was high with coerced treatment and that clinical outcomes are indistinguishable between coerced and non-coerced clients (Farabee, Prendergast & Anglin, 1998). One of the latest of these studies actually found that legally mandated clients did better than either criminal justice clients who were not mandated or clients entering treatment with no criminal justice involvement. At follow-up, the mandated clients were more likely to be abstinent, in stable remission and have no identifiable substance-related consequences (Kelly, Finney & Moos, 2005). The National Institute on Drug Abuse examined studies on this issue and their findings are that "individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily" (NIDA, 1999). There is a growing professional consensus that motivation for recovery should be viewed as an outcome of early treatment, not a required ticket of admission to enter treatment (White, Boyle & Loveland, 2002) or grounds for expulsion from treatment (White, Scott, Dennis & Boyle, 2005).

Is the use of treatment by the criminal justice system cost-effective?

Treatment interventions across multiple points in the criminal justice system have been found to have significant effects on enhancing long-term recovery, reducing criminal recidivism and reducing the social cost of addiction—particularly criminal justice costs. Drug treatment programs in prisons, such as the widely acclaimed "Delaware Model" combined with work-release reduced the probability of re-arrest following release by 70%. (Source: http://www.nida/nih.gov/PODAT/PODAT6.html)
Similarly positive findings have been reported on post-release treatment (McCollister, French, Inciardi, Butzin, Martin & Hooper, 2003).

What can the criminal justice system do to improve treatment outcomes?

The criminal justice system can exert its influence in a number of ways to improve treatment outcomes for the substance-impaired offender. Given our review of treatment outcome literature, we think the most significant of these actions would include:

- Using assessment protocol that emphasize the identification of offender assets ("recovery capital") as well as problems (Granfield & Cloud, 1999),
- using external coercion to engage the offender in an assessment and treatment process,
- monitoring treatment engagement to insure an adequate dose of treatment and to enhance the probability of successful completion of a primary course of treatment,
- encouraging and facilitating family involvement in the treatment process,
- monitoring and encouraging participation in a structured program of aftercare following services,
- encouraging the development of a sobriety-based social support system,
- monitoring post-treatment functioning and providing feedback, linkage to recovery supports and, when needed, early re-intervention, and
- acting swiftly to correct noncompliance with court orders.

We would also recommend that probation officers orient each offender to the particular treatment program to which they are being referred. We suspect that such individual or group pre-treatment orientation would contribute significantly to treatment engagement and treatment completion rates.

How important is monitoring to long-term recovery?

Several reviews (e.g. Westermeyer, 1989) of factors effecting treatment outcome make special note of the potential role of monitoring in long-term outcomes. Such sustained monitoring takes on added significance in light of "treatment careers" research (Hser, et al., 1997), new recovery management models (White, Boyle, & Loveland, 2002), and recent studies on the potential value of post-treatment monitoring and recovery support services (Dennis, Scott, & Funk, 2003). These innovative studies underscore several key points:

- A single, acute intervention rarely has sufficient effect to initiate stable and enduring recovery in those with severe and persistent alcohol and other drug problems.
- Multiple episodes of treatment may be viewed, not as failures, but as incremental steps in the developmental process of recovery.
- Treatment effects not visible following a single episode become discernable when viewed over the longer history of treatment and recovery. Treatment episodes may have effects that are incremental and cumulative.
- The treatment of individuals with severe substance use disorders needs to shift from serial episodes of brief intervention to a model of sustained recovery management, e.g.,

active engagement, motivational enhancement, support for treatment retention, post-treatment monitoring and recovery support services, stage appropriate recovery education, active linkage to local communities of recovery, recovery checkups, and, when needed, early re-intervention and re-engagement in treatment.

These findings underscore the need to: 1) distinguish between a lapse (episode of drinking or drug use following by re-commitment to recovery) and a relapse (more extensive periods of use and AOD-related problems that may include criminal recidivism and threats to public safety, and 2) maintain systems of rigorous surveillance and re-intervention with those offenders who post a potential threat to public safety.

How important is drug testing as a monitoring tool?

Drug testing serves multiple purposes in the criminal justice system: a routine monitoring tool at the point of arrest, 2) a tool to identify breaches in compliance with court orders, 3) a means of monitoring treatment and post-treatment rehabilitation status, and 4) a device to reduce drug use inside correctional facilities. Sanctions for positive drug tests vary depending on the purpose for its use. Evaluations of the effectiveness of drug testing have found that 1) drug testing alone can reduce criminal recidivism, 2) drug testing combined with treatment generates greater reductions in recidivism and 3) drug testing reduces drug use inside correctional institutions (Harrell & Kleinman, 2000; MacPherson, 2004). (Source: http://www.sppsr.ucla.edu/ps/webfiles/faculty/kleiman/drug_testing.pdf). Another less recognized rationale for drug testing is that it provides a culturally accepted rationale for refraining from drug use when an offender finds himself in a situation where he or she is offered drugs.

The question of the ideal frequency of drug testing varies by setting (use during treatment versus use as part of probation supervision) and by individual offender. For treatment programs in Illinois that conduct drug testing, the frequency ranges from three times per week to monthly, and the frequency of drug testing in probation departments in Illinois ranges close to the same with drug courts using a higher frequency of drug testing.

What new technologies are available to assist in monitoring offenders with AOD problems?

New technologies that are being used to monitor alcohol and drug use include:

- saliva and hair testing as an alternative to the chemical testing of urine,
- a new generation of alcohol monitoring devices including such products as the SCRAM (Secure Continuous Remote Alcohol Monitor)—a device that transmits data collected from an ankle bracelet that measures exposure to alcohol by the amount of alcohol that passes through the skin,
- remote electronic alcohol monitoring devices that combine random call schedules with a device that measures and transmits alcohol exposure through a voice-recognition, camera-rigged breathalyzer (e.g., products like the Sobrietor),
- GPS tracking devices (e.g., the iSECUREtrac) that can identify the location of an offender at any time to monitor movement of the client into prohibited locations, and
- Ignition Interlock Devices (a breath-testing unit connected to a car's ignition) that prevents operating the vehicle when the driver is under the influence of alcohol).
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What should the criminal justice system's response be to episodes of offender AOD use while under supervision?

There are two important principles to guide such responses. First, there should be a response of some kind to every episode of use that is reported or detected. Second, the nature of that response

should be nuanced based on the quantity and duration of use, the circumstances surrounding use and the collateral activity related to the use incidents. As we have noted earlier, most people who achieve stable recovery experience one or more lapse or relapse episodes before achieving stable sobriety. The goal of the criminal justice system in working with offenders with substance use disorders is to: 1) minimize the number of such episodes, 2) prevent or minimize the collateral criminal and public safety threats related to such incidents, 3) interrupt such episodes at the earliest possible point, and 4) use lapse/relapse incidents as opportunities to strengthen the commitment to recovery and improve methods of recovery maintenance. We recommend a triaged response from increased surveillance (e.g., reporting, drug testing) through re-engagement in treatment services to brief jail time to more extended jail sentences. Such responses could differ significantly between those offenders who are grossly out of compliance ("trail and nail"), those who have the greatest potential for recovery (monitor and support) and those who are superficially compliant (low maintenance monitoring).

What population of offenders deserve a higher allocation of time and more intense monitoring?

Courts and probation departments differ in their philosophies over which offenders should receive the greatest concentration of scarce resources, e.g., offenders with the best prognosis for recovery, offenders with the highest risk of chemical and criminal relapse or offenders with the highest potential threat to public safety. There is a trend toward using the latter category to focus the most assertive monitoring. What this means in practice is aggressive supervision is directed toward those who have a substance use disorder whose other characteristics heighten their threat to the public. Probation departments in Illinois are identifying sex offenders, domestic battery recidivists and DUI recidivists in this category.

Are there any emerging principles to guide the management of the substance-impaired offender?

There are four principles that we think can enhance rehabilitative outcomes and enhance the protection of public safety (White, 2004).

Clarity and Consistency Principle: This principle requires three strategies: **1) d**efining expectations of each offender in behavioral terms (It is our experience that judges and probation officers get what they expect and monitor e.g., probation officers who expect and monitor payment of fines have higher collection rates than probation officers who never inquire about the status of fines.), 2) linking the intensity of rewards and punishments to the degree of compliance or non-compliance with those terms, and 3) getting multiple forces in the offender's environment (the courts, allied agencies, family members, employers) to understand and reinforce those expectations.

Dose and Intensity Principle: Insuring an adequate dose of treatment and an appropriate level of treatment intensity improve rehabilitative outcomes. Longer courses of treatment and continuing care services, multiple points of accountability with the courts and extended external monitoring (e.g., probation supervision and drug testing) are highly recommended for those with severe substance use disorders. There is also little evidence that low-intensity interventions have any rehabilitative effects on persons with severe substance use disorders, e.g., addicted DUI offenders passively attending remedial education classes.

Combination Principle: We have yet to develop effective technology that scientifically matches each offender to the ideal sentence and rehabilitative strategy. As a result, combinations of interventions are always more effective in the long run than single interventions. Combinations of interventions (probation supervision, fines, community service) generate better outcomes than any single intervention.

Containment Principle: There are offenders at particular points in their lives in which no rehabilitation interventions will produce stable recovery or lower their threat to public safety. Under these circumstances, the role of the criminal justice system and human service professionals is to

contain these individuals within the limits of criminal law and within the boundaries of the laws with professional ethics guiding the delivery of treatment services.

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Appendix

Addiction Recovery and Related Mutual Aid Groups in America

Al-Anon Family Groups, Inc., 1600 Corporate Landing Parkway, Virginia Beach, VA 23454-5617. (757) 563-1600 or (888) 4ALANON for meeting information; http://www.al-anon.alateen.org/.
Alcoholics Anonymous (AA), General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163; (212) 870-3400; www.aa.org.
Online Intergroup of Alcoholics Anonymous; see http://aa-intergroup.org for information about online AA Groups.
Sober 24; an online 12 step recovery support group resource; http://www.sober24.com.
Deaf and Hard of Hearing 12 Step Recovery Resources; A web site that provides recovery resources for deaf and hard of hearing persons, http://www.dhh12s.com/index.htm.
Alcoholics Victorious (AV), a Christ-centered 12 Step program**;** 1045 Swift Street, Kansas City, MO 64116; (816) 471-8020; http://av.iugm.org.
Cocaine Anonymous (CA); http://www.ca.org.
Depressed Anonymous (DA) A 12-Step program for persons suffering from chronic depression; Coordinator Depressed Anonymous, PO Box 17414, Louisville, KY 40217; (502) 569 1989 or email info@depressedanon.com; http://www.depressedanon.com/index.html.
Double Trouble in Recovery (DTR), "a recovery group for the dually diagnosed," Howie Vogle; Email: HV613@aol.com; phone (718) 373-2684; P.O. Box 245055 Brooklyn, New York 11224; http://www.doubletroubleinrecovery.org.
Dual Recovery Anonymous (DRA); 12-step program for people with a dual diagnosis; Dual Recovery Anonymous World Service Central Office, P.O. Box 8107, Prairie Village, KS 66208. Toll Free (877) 883-2332; http://www.dualrecovery.org.
Families Anonymous (FA); a Twelve Step program for relatives and friends of those who have alcohol, drug or behavioral problems; P.O. Box 3475, Culver City, CA 90231-3475; FA World Service Office (800) 736-9805 or by email at famanon@FamiliesAnonymous.org; http://www.familiesanonymous.org.
Gamblers Anonymous (GA); P.O. Box 17173, Los Angeles, CA 90017; (213) 386-8789; http://www.gamblersanonymous.org.
Gam-Anon Family Groups; Twelve Step program for family and close friends of compulsive gamblers; Gam Anon, P.O Box 157, Whitestone, NY 11357; (718) 352-1671; http://www.gam-anon.org.
Grief Recovery After Substance Passing (G.R.A.S.P.); support group for those who have lost someone due to substance use; Call (619) 656-8414 or email mom@jennysjourney.org; http://www.grasphelp.org.
GROW, Inc.; a mutual help program for those recovering from depression, anxiety and other mental health problems; 2403 W. Springfield Ave., Box 3667, Champaign, IL 61826; (217)352 6989;
Jewish Alcoholics, Chemically Dependent Persons and Significant Others (J.A.C.S); a 12 Step support group integrating Alcoholics Anonymous and Judaism; 850 Seventh Avenue, New York, NY 10010; (212) 397-4197; http://www.jacsweb.org.
LifeRing Secular Recovery (LSR); secular program of recovery; http://www.unhooked.com.
Marijuana Anonymous (MA); Marijuana Anonymous World Services, P.O. Box 2912,Van Nuys, CA 91404, (800) 766-6779; www.marijuana-anonymous.org.
Methadone Anonymous Support; a 12 Step program for people recovering from opiate addiction; email methadoneAnonymous@neo.rr.com; http://www.methadonesupport.org

Millati Islami; a Muslim 12 step program to combat alcohol and drug addiction; http://www2.islamicity.com/al-muminun/MIFAX/mifax.htm.

Moderation Management (MM); Support group for problem drinkers who want to reduce their drinking and make other positive lifestyle changes; Moderation Management Network Inc., PO Box 3055, Point Pleasant NJ 08742; (732) 295-0949; email moderation@moderation.org; http://moderation.org.

Narcotics Anonymous (NA); a 12 Step program for persons recovering from addiction to drugs other than or in addition to alcohol; P.O. Box 9999, Van Nuys, CA 91409; (818) 773-9999; http://www.na.org.

Nicotine Anonymous; a 12 Step program for persons recovering from nicotine addiction; Nicotine Anonymous World Services, 419 Main Street, PMB#370, Huntington Beach, CA 92648; (415) 750-0328; email info@nicotine-anonymous.org; http://www.nicotine-anonymous.org.

Overcomers Outreach; a Christian recovery ministry that utilizes the 12 steps of Alcoholics Anonymous along with scriptures; PO Box 2208, Oakhurst, CA 93644. (800) 310-3001; http://overcomersoutreach.org.

Recovery, Inc.; a community mental health organization that offers a self help method of training for the management of troublesome behavior and emotions; 802 N. Dearborn St., Chicago, IL 60610; (312) 337-5661; http://www.recovery-inc.com.

Schizophrenics Anonymous; Offers a 6 step program, fellowship, support and information for people with schizophrenia; Schizophrenics Anonymous, National Schizophrenia Foundation, 403 Seymour, Suite 202, Lansing, MI 48933; (517) 485-7168; Mental Health Consumer line: (800) 482-9534; e-mail sareferrals@nsfoundation.org; http://www.nsfoundation.org.

Secular Organization for Sobriety/Save Our Selves (S.O.S.); a secular program of addiction recovery; Contact Jim Christopher, 4773 Hollywood Blvd., Hollywood, CA 90027 (323) 666-4295.; Email SOS@CFIWest.org; http://www.cfiwest.org/sos.

SmartRecovery®; a secular program of addiction recovery; 7537 Mentor Avenue, Suite #306, Mentor, Ohio 44060, Toll-Free: (866) 951-5357 or (440) 951-5357; http://www.smartrecovery.org.

Sober City; a virtual online community to support people suffering from alcoholism and addiction; http://www.sobercity.com.

SoberDykes Hope Page; online support for women in recovery from addiction and psychiatric illness; links to many gay and lesbian recovery resources; http://www.soberdykes.org.

Women for Sobriety (WFS); offers a Thirteen Statement Program encouraging positive growth for recovering women; WFS, Inc., P.O. Box 618, Quakertown, PA 18951-0618; (215) 536-8026; http://www.womenforsobriety.org.

Source: This list has been abstracted from “Mutual Support Resources Guide” developed by Drs. Linda and Ernie Kurtz posted at http://www.facesandvoicesofrecovery.org/resources/support_home.php. Additional information on these groups and how to work with them can be found at this web site.



Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W.L. & Webber, R. (2006). La Historia del Tratamiento Farmacológico para los Desórdenes del Uso de la Sustancia (The History of Pharmacological Treatment for Substance Use Disorders). In: F. López-Muñoz, F. & Alamo, C. (Eds.), La Historia de la Psicofarmacología, Madrid: Editorial Médica Panamericana, pp. 887-898.Posted at **www.williamwhitepapers.com**

History of Pharmacological Treatment for Substance Use Disorders

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The pharmacological treatment of substance use disorders developed in tandem with the medicalization of these problems in the late eighteenth and early nineteenth centuries (Levine, 1978). Dr. Benjamin Rush (1784) described one of the earliest pharmacological treatments for chronic drunkenness—the use of an emetic to create a conditioned aversion to alcohol. During the nineteenth century, pharmacological adjuncts were used within the inebriate asylums and private addiction cure institutes in the United States and Europe. Agents used to aid detoxification included alcohol, chloral hydrate, strychnine, mercury, arsenic, atropine, belladonna, hyoscyamus, coca, cannabis indica, opium, atropine, hyoscyamus, belladonna, sulphur, quinine, and paraldehyde. Many of the addiction cure institutes (e.g., the Keeley Institutes) centered their treatments on medicinal specifics (usually combinations of strychnine, atropine, cocaine, codeine, and apomorphine) that promised to destroy the morbid craving for alcohol and opiates. These specifics were also sold as bottled home cures. The success of the Keeley products spawned many patent medicine cures for addiction. Repeated exposϑs of addiction cures that secretly contained alcohol, opium, morphine and cocaine led to prescription and product labeling laws (White, 1998).

The use of cocaine as a treatment for alcoholism and morphine addiction achieved brief popularity. Medical reports as early as 1880 described successfully treating morphine addicted patients with pounds of prescribed cocaine (Bently, 1880). The most famous of such claims was Sigmund Freud's 1884 laudatory essay on cocaine was retracted in 1887 with an acknowledgement of cocaine's addiction potential. Another unusual treatment for alcoholism in the 1880s involved the substitution of opiates for alcohol. This substitution was recommended on the grounds that morphine was cheaper and less physically (Black, 1889).

Pharmacological adjuncts in the treatment of alcoholism during the early twentieth century included a surge in interest in apomorphine, ipecac, and other emetics as aversive agents (Crothers, 1902). These treatments became particularly popular in Europe following experiments by Russian researcher N.V. Kantorovich in the 1920s and the development of clinical protocol for the use of apomorphine by English physician, Dr. John Dent. The treatment of alcoholism using aversion therapy was later re-popularized in North America by Dr. Walter

Voegtlin and Dr. Frederick Lemere at the Schick's Shadel Hospitals (Shadel, 1944). Early twentieth century treatments for alcoholism also included experiments with an alcoholism vaccine; use of a mixture of belladonna, hyoscyamus and xanthoxylum; glucose and insulin injections; and experiments with metrazol- or cardiazol-induced convulsions (Sournia, 1990; Corwin and Cunningham, 1944).

There were three approaches to narcotic withdrawal in the late nineteenth and early twentieth centuries: 1) rapid and complete withdrawal, 2) gradual withdrawal utilizing a step-down of drug dosage over a short period of time, and 3) prolonged withdrawal over an extended period of time. Pharmacological adjuncts used to facilitate these processes included narcotic substitutes (e.g., codeine); non-narcotic substitutes (cannabis indica, strychnine, belladonna, atropine, cocaine, quinine, whiskey, and coffee); purgatives to speed the elimination of toxins; sedatives to provide comfort and sleep (e.g., chloral hydrate, bromides, sulphonal, trional, and veronal); aversive agents (e.g., tartar emetic); drugs whose resulting disorientation reduced flight from treatment (e.g., hyoscine or atropine); and plant specifics thought to destroy narcotic craving (e.g., Avena sativa or Viola sagittata) (Kolb & Himmelsbach, 1938).

Formal narcotic addiction withdrawal protocols of the early twentieth century included the Lambert-Towns treatment (a combination of belladonna, xanthoxlyun, hyoscyamus, strychnine, and digitalis), the Petty method (atropine, scopolamine, sparteine sulphate, and sodium thiosulfate), the Sceleth method (scopolamine, pilocarpine, ethyl-morphin, strychnine, and various cathartics), the Nellens and Massee method (mercurous chloride, magnesium sulphate, and chloral) and Narcosan treatment (a mixture of lipoids, proteins, and vitamins). There was also a brief (1919-1925) American experiment with morphine maintenance clinics as a method of treating intractable addiction, but these clinics closed when physicians were threatened with federal indictment (White, 1998). Some therapies of this period defy explanation: “serum therapies” in which blisters were raised on the addict’s abdomen and thighs and then the fluid from the blisters was withdrawn and re-injected into the addict during narcotic withdrawal; “blood therapies” in which blood was withdrawn and then re-injected during withdrawal; and “bromide sleep treatments” that had mortality rates of 20 percent (Kolb & Himmelsbach, 1938; Kleber & Riordan, 1982).

Several pharmacological advancements occurred in the treatment of alcoholism in the mid-twentieth century, including the introduction of vitamin B-3 (Niacin) and related nutritional therapies, brief experiments in the use of a variety of adrenal steroids and adrenocorticotropic hormones, and the use of tranquilizers, sedatives and amphetamines (Corwin and Cunningham, 1944). Sedatives and amphetamines (Bloomberg, 1939) were prescribed to treat the depression thought to be the etiological source of alcoholism. These substances fell out of favor in the treatment of alcoholism following discovery of their abuse addictive potential. However, benzodiazepines (particularly chlordiazepoxide (Librium®) and diazepam (Valium®) continued to be used in alcohol detoxification and presently are the medications of choice for that purpose. Other drugs used in the treatment of alcoholism during the mid-twentieth century include Lithium and various anti-depressant medications.

Disulfiram, was introduced in 1947 by two Danish researchers, Jens Hald and Erik Jacobsen, following discovery that disulfiram interfered with the breakdown of alcohol, resulting in flushing, sweating, nausea and other unpleasant side effects (Hald & Jacobsen, 1948). As an adjunct in the treatment of alcoholism, it was hoped disulfiram would provide a chemical shield protecting the alcoholic from a return to drinking. Although disulfiram and drugs with similar effects were widely marketed under such trade names as Antabuse, Abstinyl, Antiethyl, Aversan, Contralin, Esperal, Stopetyl, Refusal, Temposil, and Abstem and continue to be used in many parts of the world, their utility has been limited by medical contraindications for some patients, unpleasant side-effects, the requirement for continued voluntary or monitored administration,

and research findings suggesting a substantial placebo effect and only modest (at best) specific effect (Miller, & Hester, 1986).

LSD was introduced into the treatment of alcoholism by two Canadian psychiatrists, Dr. Abram Hoffer and Dr. Humphry Osmond. Between 1949 and 1966, LSD was employed by many researchers and psychotherapists to treat of alcoholism. The use of LSD in the treatment of alcoholism faded with its emergence as a drug of abuse and controlled studies that challenged claims of its effectiveness (Miller & Hester, 1986).

Mid-twentieth century treatments for narcotic addiction paralleled treatments for alcoholism, e.g., insulin-coma therapy, "hibernation therapy" (withdrawal aided by sodium pentothal narcosis), apomorphine and socinyl choline to induce aversion to narcotics, phenothiazines as an aid in withdrawal, LSD as an adjunct in psychotherapy, and the use of methamphetamine as a medically prescribed substitute for heroin (Kleber and Riordan, 1982).

Nalline (nalorphine), a semi-synthetic derivative of morphine with narcotic antagonist properties, was synthesized in 1941 and was followed by other antagonists, e.g., naloxone, cyclazocine, pentazocine, naltrexone and buprenorphine. In the early 1960s, William Martin and Abram Winkler began using daily doses of a narcotic antagonist to block the euphorogenic effects of narcotics. An early review of these procedures by Senay and Renault (1971) found problems related to unpleasant side effects, effectiveness contingent upon high patient motivation, and severe withdrawal following regular use. Later reviews noted particular populations (e.g., opiate-addicted physicians) for whom antagonist therapy was highly effective (Washton, Gold, and Pottash, 1984).

Dolophine (methadone), a long-acting synthetic narcotic that was developed in Germany in 1943, has played a unique role in the modern treatment of narcotic addiction. It first entered addiction treatment in the late 1940s as a detoxification agent. In 1964, two American physicians, Dr. Marie Nyswander and Dr. Vincent Dole (1968), announced a new protocol for the treatment of heroin addiction that used orally administered "blockade" doses of methadone as a maintenance agent for chronic opiate addicts. Early evaluations of methadone maintenance treatment revealed substantial effects in reduced drug use, criminal activity and health-related problems and increased rates of employment and psychological and social health (Senay & Renault, 1971).

Although Methadone continues to be the dominant medication used in the treatment of opiate addiction, LAAM (levomethadyl acetate hydrochloride) was tested in the latter 1970s as a pharmacologic alternative. Originally synthesized in 1948 as an analgesic, LAAM was found by Fraser and Isabel (1952) to suppress opiate withdrawal symptoms for more than 72 hours. Studies conducted during the 1970s found that orally administered LAAM has the same ability as methadone to block the actions of other opiates (e.g., heroin) while alleviating narcotic withdrawal symptoms, and to have no adverse effects (National Institute on Drug Abuse, 1993). Methadone clients who were given LAAM indicated that they preferred the latter because it made them feel "more stabilized" (Goldstein, 2001). However the drug languished until the HIV/AIDS epidemic began to spread to intravenous injection drug users in the 1980s. LAAM was approved by the FDA as a pharmacological treatment for opiate dependence in 1993, but never achieved widespread use.

A major shift in the science of opiate detoxification occurred when research was published showing that Catapres® (clonidine), an alpha 2-adrenergic agonist primarily used to treat hypertension, was capable of suppressing a wide range of opiate withdrawal symptoms (Gold, Pottash, Sweeney & Kleber, 1980). Unlike all previous medications used for this purpose, clonidine does not produce sedation or intoxication nor occupy brain opiate receptor sites, but rather acts on the locus ceruleus to suppress adrenergic activity and reduce the intensity of withdrawal symptoms. Clonidine does produce light-headedness, faintness or postural

hypotension in some patients, even at relatively low doses. However, in patients who can tolerate clonidine, these same side effects as well as the drug's lack of sedating and intoxicating effects discourage drug-seeking behavior and requests for higher doses that can occur in methadone-maintained clients. Clonidine has also been used as a final detoxification agent following decreasing doses of methadone (Kleber, Gold & Riodan, 1980). A related substance, lofexidine, a structural analogue of clonidine, was found to be equal to and in some cases superior to the latter in the detoxification of opiate addicts. It has been used in the United Kingdom since 1991 under the brand name BritLofex to withdraw patients from opiates.

Buprenorphine is an atypical narcotic with both agonist and antagonist properties, i.e., it produces typical opiate effects and will prevent withdrawal symptoms in dependent drug abusers at lower doses but can block the effects of "full agonists" such as heroin and precipitate withdrawal symptoms at higher doses. In October 2002, the FDA gave approval to market a sublingual buprenorphine monotherapy product, Subutex®, and a buprenorphine/naloxone combination product, Suboxone®, for use in opioid addiction treatment. The combination product is designed to decrease the potential for abuse by injection, since naloxone produces antagonist effects when administered intravenously, but does not do so when taken sublingually. The approval of buprenorphine ushered in a new era in the treatment of opiate dependency in the United States since licensed physicians trained in the use of the drug were allowed to dispense it from their offices.

The precipitous increase in the use of cocaine in the 1970s and 1980s led to increased research into pharmacological methods of treatment. The goal of pharmacological treatment is to prevent or minimize the potential for cocaine relapse by reducing depression, anxiety and drug hunger. The neurochemical mechanism that underlies these withdrawal problems (depletion of adrenergic neurotransmitters- particularly dopamine) was understood by the 1970s, and most approaches to the pharmacological treatment of cocaine dependency centered on normalizing brain chemistry. Drugs tested for their potential use in the treatment of cocaine dependency included the tricyclic antidepressants (Gawin & Kleber, 1984), MAO-A/B-inhibitors (e.g., phenelzine) (Maletzhy, 1997), bromocriptine (Parlodel®) (Dackis and Gold, 1985), fluoxetine (Prozac®) and sertraline (Zoloft®) (Kosten, et, al., 1992; Covi, et. al., 1994), methylphenidate (Ritalin®) (Khantzian, Gawin & Riordan, 1984), and amantadine (Symmetrel®). While initial reports were positive, further studies revealed mixed or harmful results (Gawin, Riordan, and Kleber, 1985; Weiss, 1988; Handelsman, Rosenblum, et. al., 1997).

In the early 1990s, the National Institute on Drug Abuse commissioned a meta-analysis of the existing literature on the pharmacological treatment of cocaine dependency. The resulting report indicated that Antabuse was the only medication that consistently reduced the incidence of cocaine relapse (Rawson, 1993). Initially, it was hypothesized that disulfiram simply reduced cocaine relapse by discouraging alcohol consumption and thus the impairment of judgment and impulse control that often results from drinking. Later, however, it was found that disulfiram reduces the presence or intensity cocaine craving and/or reduce the intensity of cocaine reward (Petrakis, Carroll, Nich, et. al., 2000) due to its effect on dopamine and norepinepherine.

Recent animal research (Woolverton, et. al., 2002) has held out the hope the cocaine analog, (+)-CPCA ("norcaine") might be useful in mitigating the aversive effects associated with cocaine abstinence. A final medication that appears to hold promise for the treatment of cocaine dependence is gamma vinyl-GABA (GVG), an anti-epilepsy drug marketed as Vigabatrin®. GVG is known to inhibit dopamine increases in the nucleus acumens, a vital part of the human "reward pathway", and a site of action for most abused drugs (Gerasimov, Ashby, Gardner, et, al., 1999). Investigators conducted a study in which daily administration of GVG over a period of 2-3 weeks reduced and eventually eliminated craving for cocaine (Brodie, Figueroa & Dewey, 2003).

On-going research has also led to the realization that medications previously thought to be helpful in treating only limited types of dependency might have a much broader applicability. The finding that administration of naltrexone to animals could decrease consumption of alcohol led to the initiation of studies using human subjects, and subsequently, two studies demonstrated that naltrexone could have the same dampening effect on drinking in human subjects (Volpicelli et al., 1992; O'Malley, Jaffe, et. al., 1992). In 1994, the FDA officially approved the use of naltrexone for the treatment of alcoholism. A naltrexone metabolite, 6-beta naltrexol, has shown promise for drinkers whose pre-existing liver damage precludes their use of naltrexone. Animal studies involving 6-beta naltrexol have produced hopeful results, and it has been found that this drug has a longer duration of action than its parent compound (Rukstalis, et. al., 2000). Recent research has also focused on Acamprosate (calcium acetylhomotaurine). Although this drug is not yet approved for use in the United States, studies in Europe have shown that acamprosate appears to reduce relapse rates following a period of abstinence, perhaps by blunting the euphorigenic effects of alcohol. Acamprosate is commonly thought to work by simultaneously inhibiting the receptors of the inhibitory neurotransmitter, GABA and while enhancing those of N-methyl-D-aspartate (Berton, et. al., 1998). One major advantage of using this drug is that it is not significantly metabolized in the liver, making it safer for those with liver disease.

In the early years of the 21st century, interest in the use of ibogaine has increased virtually worldwide. Ibogaine is an indole hallucinogen derived from the root of the African shrub Tabernanthe iboga, which has traditionally been used as a medicinal and ceremonial agent in West Central Africa. Although no controlled scientific studies have been done with humans, anecdotal reports, some published in major journals, have indicated that single dosages of this substance appears to reduce or eliminate craving for abused substances in addicted individuals as well as alleviate withdrawal symptoms associated with cessation of heroin, cocaine and alcohol dependence (Sheppard, 1994). The hypothesized mechanism for such effects is a yet-unspecified “resetting” or adaptation of neurotransmitter levels. Although such reports seem incredulous, they come from credible sources, and cause one to wonder what the future of pharmacological treatment of addictive disorders may bring.

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Citation: White, W.L., Laudet, A.B. & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional*, 4(4), 18-23. Posted at www.williamwhitepapers.com

Life Meaning and Purpose in Addiction Recovery

William L. White, MA, Alexandre B. Laudet, PhD and Jeffrey B. Becker, MSW, MPH

* *Once you have no hope, no goals or no dreams, you're just waitin' to die.*

* *God gives you the means to get clean, now what you gonna do with that life?*

--Voices of recovering addicts in New York City

In the transition from addiction to recovery, each client must find ways to draw life meaning and purpose from the addiction and recovery experiences, forge new prescriptions for daily living, and generate hope for the future. To more deeply understand the role of meaning and purpose in the recovery process, the authors conducted 354 semi-structured interviews and 50 in-depth qualitative life history interviews with New York City residents in addiction recovery. The semi-structured interviews are being repeated annually over a span of four years. Most of those interviewed have prolonged histories of multiple drug dependence (predominantly crack cocaine, heroin, and alcohol) and numerous collateral problems (including homelessness, HIV, and co-occurring psychiatric illness) (White & Laudet, 2006). This article highlights some of the key findings of this study, illustrates those findings using excerpts from the interviews, and discusses the potential implications for the practice of addiction counseling.

Sense-making in Recovery

There is a growing diversity of religious, spiritual, and secular frameworks of addiction recovery (White & Kurtz, 2005). While individuals representing these varieties of recovery experience are often juxtaposed against one another in acrimonious debate, these frameworks of recovery share much in common. All help their members answer, albeit in very different ways, five recovery-crucial questions:

1) Why and how did this happen? (Why me?)
2) What does it mean to have this problem? (How has this problem changed me and my most important relationships and activities?)
3) How did I come to escape this problem? (Why have I survived when others have not? Where does my recovery story begin?)
4) What actions do I need to take today to sustain my recovery?

5) How does this problem affect the future direction of my life? (What is my personal destiny as a person in recovery?)

Such questions are a normal process of constructing meaning and redefining self and the self-world relationship in the face of serious illness (Fife, 1994). Answering these questions provides a way to escape self-censure and social stigma and a means of positively coping with the loss of personal power and control. Whether framed in religious, spiritual, or secular terms, these answers constitute the building blocks of recovery and can be collectively framed within the rubric of life meaning and purpose (LMP).

Role of LMP in Recovery

Life meaning and purpose link past, present, and future. Meaning focuses on rendering our past coherent and giving value to our present, and purpose provides a framework for linking present activities to a desired future. Recent studies of addiction recovery suggest that LMP play an important role in the recovery process (Carroll, 1993). Some of the clinically significant findings and tentative observations from these studies include the following.

- LMP in addiction recovery is often defined in the context of multiple conditions, e.g., developmental trauma/loss, co-occurring medical or psychiatric illness, poverty, homelessness.
- The development of LMP in recovery often occurs in the context of catalytic metaphors (through which previously inexplicable struggles become understandable), empowering relationships, and the experience of connection to community (White, 2004; White & Sanders, 2004).
- LMP can serve as a catalyst of recovery initiation, an anchor for recovery maintenance, and a source of recovery enrichment (Laudet, Morgen, & White, 2006).
- LMP significantly enhances the likelihood of successful recovery maintenance (Laudet, White, & Storey, in press).
- Recovery-inciting LMP can be experienced suddenly in a transformative revelation that is unplanned, positive, and permanent or through an extended process of self-awakening (Miller & C'de Baca, 2001).
- LMP can occur in the context of self-surrender and self-transcendence (connection with resources outside the self) or through a process of self-assertion (discovery of hidden resources inside the self and acts of personal resistance/defiance).
- LMP evolves across the stages of recovery and across the developmental stages of life. The LMP that anchors early recovery may have to be redefined in later stages of recovery.
- Life meaning and life purpose are forms of recovery capital (internal and external assets that mediate long-term recovery outcomes); LMP can be increased through the guidance of addiction professionals and recovery support specialists.

Asking those in recovery about the importance new life meaning and purpose played in their recovery processes generated responses such as the following.

> *I need to have a reason to stay sober. … I asked myself the question, "Why am I here? Just to drink?" No, a sense of purpose gives me something to work with. Everybody don't go to meetings or to church or believe in a higher power. You've got to have a purpose, something that you believe in.*
>
> *You have to hold on to something that gives you purpose for taking another breath.*

One of our respondents drew meaning from having fallen and broken his leg in the panic that followed the attacks on the World Trade Center on September 11th, 2001.

> *That particular day I was there for a purpose--maybe for me to go through this metal thing with my leg, so that I could be here and maybe learn things about myself. There's gotta be a purpose; I know I haven't gone through all of this pain for nothing.*

Sources of Life Meaning and Purpose

In our interviews with people recovering from addiction in New York City, LMP was described within explicitly religious, spiritual, and secular terms. We found four primary sources of LMP shared across these recovery frameworks: 1) survival, 2) self-reclamation, 3) service to others, and 4) connection to community.

Survival in Spite of All Odds: Those we interviewed shared a mixture of awe, wonder, gratitude, and indebtedness regarding their own survival. They came to understand that survival in terms of a greater purpose and personal destiny.

> *Look at them. They're all dead. If it's not the virus, it's an overdose… Why do you think I'm alive? You have to talk to God about that, but it must be for a purpose.*

> *God didn't abandon me; I still had his grace. I understood that I was chosen and that I have a purpose. Helping somebody, that's my purpose. All that I went through wasn't in vain.*

One participant described being shot and then immediately experiencing the incongruity between escaping death and continuing to waste his life as an addict.

> *God, he must have a purpose for me because he saved me that day they shot me. And I looked at me--what I'm doing with the life that he gave me back, using drugs and walking around the street like a bum…I knew that I should be doing something more positive and constructive than using drugs and beating myself up in the street, killing myself.*

Another person in recovery found purpose in transcending his own efforts at self-destruction.

> *I always wondered, "Why am I still here?" I tried to kill myself--commit suicide--and I'm still alive. I felt so low that I injected myself with battery acid and didn't call 911 or tell a friend or anybody. I wanted to die, but I didn't. I woke up and said, "Why am I here?" Now I know. My message will get across, one way or another, but I'd rather speak it than deliver it in a casket.*

Self-reclamation: A central theme in the addiction stories we heard was that of loss of self. The counter-theme in recovery was a reclamation or reconstruction of self.

> *I was able to open my eyes and see that I needed help. I had to get myself back together and continue to be sober and get my life straightened out.*

> *I got to live for myself. I ain't ready to die. My mother and my mother's sister died in they 30s. And I don't wanna die in my 30s. You know what I'm saying? …I wanna see forty. Or fifty.*

Part of the act of self-reclamation in recovery is the identification of excesses of character (e.g., self-centeredness, grandiosity, resentfulness, intolerance) and the cultivation of new recovery-based personal values (e.g., self-honesty, humility, patience).

Many of those we interviewed drew meaning from new values and new personal goals that emerged early in the recovery process.

I write and it's not like any other writing in this world. It's the kind of writing that touches people. God put the words in my mouth to put'em on paper so it'll touch and better the lives of many…That's when life becomes meaningful. I ain't got no kids, so that's my legacy.

Two other frequently mentioned dimensions of self-reclamation were the experiences of hope and gratitude.

What gets me out of bed in the morning? Hope. Hope for what my life could be like. … The disease of addiction doesn't want me to have any hope, wants me to think that I'll never be anything. When I go to meetings, I hear a story and meet other people who've finished school, started a family, or got their family back. That gives me hope.

I don't know why God gave me this calling. A lot of my friends have died. I used the same drugs they did, even more, and was out there for 35 years. Some of them haven't even been out there for five years and they're dead. I consider myself very fortunate and blessed. It's up to me to try to bring others back because it's sick out there.

Service to Others: People in recovery often develop a conscious orientation toward the needs of others. Those in our studies demonstrated service to others in three distinct ways. The first was through service to those injured or neglected through the addiction experience (parents, siblings, children, friends). Tales of broken and estranged relationships were often followed in recovery by stories of reconnection, restitution, and reconciliation. Many of those we interviewed talked about the meaning they drew from now living their lives for specific people who they had injured in their addiction years.

My direction is getting myself to the top shape physically, mentally and emotionally to show my children, "I'm back you all; I'm back!" That's my main purpose on this planet—to help my kids. Then I can say, "God, I'm finished."

Another client dedicated his recovery to his partner who had been murdered**.**

So, that just gonna make me stronger, it's gonna make me stronger to do the right thing, 'cause I know that's what'd she want.

A second category of service involved pursuit of the "wounded healer" tradition—service to those still suffering from addiction and those seeking recovery.

That's my primary purpose--to help other recovering addicts.

I feel that my purpose is to help somebody else, to give this message that there's hope. I'm living proof that life can get better.

One interesting aspect of service to other addicts was that the meaning is in the offering of that service and not contingent upon the nature of the response to it.

…it's like God's come to you and he's saying something through you to me. And if I'm not whipped enough or if I'm not open enough, I reject it. So your purpose was for God using you just to say it. That was your job, just to say it.

Others in recovery pursue acts of service to the larger community. Such acts came most frequently through volunteer service work.

You know, I'm part of a business meeting with the Church once a month. It's worked out well. It's given me a purpose—it means I'm doing something. I'm important. I'm needed

now and I'm loved. People look up to me to do certain things.

Connection to Community: A final source of life meaning and purpose noted by those we interviewed was their connection or reconnection to a larger community. This occurred in two ways: identification with a particular recovery community and identification with the larger group of people or all humanity.

But the basic thing is I am part of Narcotics Anonymous and I wanna stay part of the fellowship because that's the defining moment of where I fit in. I stay with that; that's my purpose.

I think the main sense of purpose is in knowing that I am part of the human race instead of feeling like a piece of shit. With drugs, you can hardly look people in the eye because you just feel so disgusted with yourself. So your purpose should be to be able to look somebody in the eye and feel good about yourself. You can't do that being addicted to drugs. You just can't.

You have an obligation that you have to be something positive in the building you live in, the job you go to, your neighborhood, your society, your country, the world. You are an individual and you fit in because there's nobody else like you. Nobody was like you before, nobody's going to be like you afterwards, so you fit in. So, you have to do your part.

There is in all of this, a stage in which addiction/recovery paradoxically shifts from the status of a stigmatized curse to a gift –a gift that opens new horizons of experience, a new sense of self, new and renewed relationships, and a new depth of living. Deep gratitude for this gift often generates feelings of indebtedness that spawn the compulsion to reach out to others in a spirit of acceptance and service.

Implications for Addiction Professionals

The early findings that are emerging from the study of LMP suggest the following ten prescriptions for addiction service professionals.

1. Raise questions related to LMP to open windows of opportunity for recovery initiation and to strengthen existing commitments to the recovery process.
2. Use hope-based methods of intervention (motivational enhancement, exposure to recovery role models) as an alternative or adjunct to pain-based interventions (coercion and confrontation).
3. Become fluent in the diverse languages of meaning reflected in religious, spiritual, and secular pathways of recovery.
4. Offer clients a broad menu of meaning-making metaphors and help each client forge personally and culturally meaningful answers to the five recovery-crucial questions.
5. Help each client construct a recovery-enhancing life story using his or her answers to those questions. (We found this rewriting of one's narrative life story to be one of the key functions of participation in 12-step recovery fellowships.)
6. Help each client set personal goals for their future in recovery.
7. Assertively link clients to communities of recovery whose members can offer mutual support in the exploration of recovery-based LMP.
8. Link clients to opportunities for community restitution and service.
9. Help relapsed clients reformulate LMP when the past source of meaning and purpose that supported recovery has been lost (e.g. loss of a catalytic relationship).
10. Recognize the potential for LMP to take both salugenic/vital (health/wholeness promoting) and pathogenic/malevolent forms

(Clinebell, 1956; Johnson, Sandler, & Griffith-Shelley, 1987).

There are many people proselytizing particular answers to LMP. What distinguishes addiction professionals in their work with LMP is their tolerance of multiple frameworks of meaning and their ability to work across these frameworks (rather than within a single framework) to help each client achieve a meaningful and purposeful recovery that fits his/her worldview and belief system. The focus of the addiction professional is not on which framework is TRUE, but on which framework can ignite, sustain, and enrich the addiction recovery process. There is a growing list of pharmacological adjuncts that can quiet the cellular demand for intoxicants, but those medications cannot answer the meaning and purpose of life in recovery. The addiction counselor can play a vital role in helping those seeking recovery to find such answers.

Acknowledgement: The study highlighted here was funded by National Institute on Drug Abuse Grant R01 DA014409 & by the Peter McManus Charitable Trust.

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EVIDENCE-BASED PRACTICE SERIES

Enhancing Addiction Recovery Outcomes through Post-Treatment Monitoring, Support and Early Re-intervention

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Definitions:

Post-treatment monitoring is a systematic process of evaluating the ongoing status of clients who have ended a course of primary treatment via completion, pre-mature disengagement (against medical/staff advice), or by administrative/disciplinary (so-called "therapeutic" discharge). The current trend is to move from passive models of aftercare (verbal encouragement for participation in continuing care groups or peer-based recovery support groups) toward models of assertive continuing care.

Assertive continuing care (ACC) is distinguished by the following:

- ACC encompasses all admitted clients/families, not just those who successfully "graduate," including those who terminated treatment against staff advice or were administratively ("therapeutically") discharged.
- Primary responsibility for post-treatment contact in ACC rests with the treatment institution, not the client.
- ACC capitalizes on temporal windows of vulnerability (saturation of monitoring and support in the first 90 days following treatment).
- ACC individualizes the duration and intensity of monitoring and support based on each client's degree of problem severity, the depth of his or her recovery capital and the ongoing stability of his or her recovery program.
- ACC utilizes assertive rather than passive (verbal encouragement only) linkage to communities of recovery.
- ACC incorporates multiple media for sustained recovery support, e.g., face-to-face contact, telephone support and mailed and emailed communications.

- ACC may be delivered either by counselors, recovery coaches or volunteer recovery support specialists
- ACC emphasizes continuity of contact in a primary recovery support relationship over time. (excerpted from White & Kurtz, in press) (Based on conversations with Dr. Mark Godley).

This more sustained and assertive style of monitoring following completion of inpatient or outpatient treatment marks a transition between *aftercare* (*follow-up*) to *continuing care* (White and Godley, 2003) and has been referred to as *extended case monitoring* (Stout, Rubin, Zwick, Zywiak & Bellino, 1999), *assertive continuing care* (Godley, Godley, Dennis, Funk & Passetti, 2002), *recovery coaching* (White, 2004a), *post-treatment recovery support services* (White, 2004b), *recovery management checkups* (Dennis, Scott, & Funk, 2003), and *focused continuing care* (Betty Ford Center).

Post-treatment support entails several critical components: 1) stage appropriate recovery education and coaching (feedback and advice), 2) assertive linkage to communities of recovery, 3) problem-solving consultation related to personal and environmental obstacles to recovery (including linkage to broader rehabilitation resources in the community), and 4) on-going assistance in building "recovery capital" (Granfield and Cloud, 1999) via reconstruction of personal identity and a sobriety-based social network.

Post-treatment early re-intervention is the process through which an individual experiencing vulnerability for or experience of a lapse or relapse is provided an intensification of monitoring and support, reconnection to indigenous communities of recovery or professional treatment toward the goal of recovery re-stabilization and facilitation of the transition into stable recovery maintenance.

History of the Practice: Addiction has been characterized as a chronic disease for well over two centuries, but it has been most often treated in acute episodes of care resembling treatment for a broken arm or a bacterial infection. This acute care model is characterized by: 1) serial episodes of self-contained, unlinked interventions (brief detoxification and psychosocial stabilization), 2) the expectation that complete and sustained recovery will follow a single episode of care, and 3) minimal resources devoted to post-treatment continuing care. An expert diagnoses and treats the problem. The service relationship ends via "graduation" and "discharge" with a few "aftercare visits," after which the patient is expected to live a sober life without further need of professional assistance.

Efforts to extend care through sustained monitoring and support date to the nineteenth century expectation of sustained correspondence between inebriate asylums and their discharged patients, the establishment of outpatient clinics to provide follow-up for discharged asylum patients, the use of workers who visited discharged patients in their homes, the linkage of discharged patients to recovery mutual aid societies and the establishment of structured aftercare groups (White, 1998). Short-lived efforts to extend treatment support have inevitably dissipated into ever-briefer models of acute intervention.

Modern efforts to extend the effects of treatment have focused on strategies to increase adherence to expectations for client participation in aftercare groups—in short, to increase the act of clients returning to the treatment facility for booster doses of professional support. Strategies that were rigorously tested and proved to increase such participation include behavioral contracting (Ossip, Van-Landingham, Prue & Rychtarik, 1984), using prompts (mailed appointment reminders and telephone reminders) (Gilbert, 1988), combining prompts and feedback (Lash & Blosser, 1999), conducting a brief aftercare orientation meeting (Lash & Dillard, 1996), and having the client participate in aftercare groups while in inpatient treatment

(Vernis & Taylor, 1994). Home-based aftercare visits were also found to be effective in enhancing recovery outcomes (Gilbert, 1988). Studies of continuing care interventions using behavioral (contingency) contracting, family involvement, case management, couples relapse prevention groups, and the community reinforcement approach also showed promise (Donovan, 1998; Godley, et al., 2002). In spite of their apparent effectiveness, these strategies never became part of mainstream clinical practice in addiction treatment. Most of these proposed enhancements constitute an effort to extend the service dose within the acute care model.

This acute care model of intervention is being challenged by a growing call for models of sustained recovery management. This latter approach emphasizes the similarities between addiction and other chronic health problems, calls for a shift in emphasis from recovery initiation to recovery maintenance, and wraps traditional treatment in a more extended continuum of recovery management support services and monitoring across episodes of care ((McLellan, Lewis, O'Brien, and Kleber, 2000; White, Boyle, Loveland, 2003).

The development and evaluation of protocol for post-treatment monitoring, support and early re-intervention is part of this broader shift toward sustained recovery management. This shift is being pushed by both recovery advocates seeking to reconnect addiction treatment to the larger and more prolonged process of addiction recovery and by a growing body of scientific studies pointing out the limitations of the acute care model. Those limitations include (See White 2004c for data references):

- Limited attraction Less than 10% of those meeting DSM-IV criteria for a substance use disorder seek treatment each year and those who do often confront and then drop out of waiting list.
- High attrition More than half of clients admitted to addiction treatment do not successfully complete treatment.
- Inadequate treatment dose Many clients received less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.
- Weak linkage to peer-based recovery support groups (Inadequate initial linkage and high early dropout rates are the norm. (Emrick, Tonigan, Montgomery & Little, 1993)
- Absence of continuing care Only 1 in 5 clients actually receive any significant continuing care contact.
- High rates of post-treatment relapse The majority of people discharged from addiction treatment resume AOD use in the year following treatment, 80% of whom resume use within 90 days of discharge.
- High rates of treatment readmission 60% of those admitted to addiction treatment already have one or more prior treatment admissions and 24% have three or more prior admissions.
- Repeated treatments preceding stable remission Most treated individuals who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years. (Dennis, Scott, Funk & Foss, 2005).
- Instability of early recovery The point at which risk of future lifetime relapse drops below 15% is not reached until 4-5 years of sustained remission and longer for those addicted to opiates)
- High post-treatment mortality Long-term follow-up studies of discharged clients reveal high mortality rates related to accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide and homicide.

These stark findings do not mean that addiction treatment has no value. Treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder

following treatment) average about one-third, substance use decreases by an average of 87% following treatment, and substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). Recent studies confirm that addiction treatment outcomes are comparable to treatment outcomes for other chronic health conditions (e.g., type I diabetes, hypertension and asthma) (McLellan, Lewis, O'Brien, & Kleber, 2000). What the literature (See later discussion) and cumulative clinical experience are demonstrating is that addiction careers can be shortened and the stability and quality of recovery enhanced by providing post-treatment monitoring, support, and early re-intervention within a framework of sustained recovery management—an approach comparable to approaches for managing other complex, chronic health problems.

Practitioner Credentials:

At the present time, post-treatment monitoring, support and early re-intervention are being conducted both by persons credentialed by education and training and by persons credentialed by experience via their own addiction and recovery careers. Service models employing the latter are often referred to as peer-based recovery support services (P-BRSS). These models deliver P-BRSS within roles bearing such titles as recovery coach, recovery support specialist, personal recovery assistant, and recovery mentor/guide. Such roles are particularly evident within two new federal initiatives—the Center for Substance Abuse Treatment's Recovery Community Support Program and the White House-initiated Access to Recovery program. There is also a trend toward the integration of recovery coaches into community-based treatment programs (see www.dawnfarm.org/articles/recoverycoach.pdf) and the development of post-treatment recovery coaching as a private business (see http://www.personalrecoveryassistants.com/ and http://www.cocaine-addiction.co.uk/recovery_coaching.htm).

Some of the key traits and areas of knowledge and skill that these programs are seeking in the recovery coaches hired to do post-treatment recovery support services include:

- Possesses credibility as a person of integrity, wisdom and compassion within the communities being served
- Knows how to make things happen even when formal resources appear to be lacking
- Exudes hope
- Possesses a deep knowledge of individual/family addiction and recovery processes
- Has a rich knowledge of the local communities and their recovery support resources
- Is knowledgeable about multiple pathways and styles of addiction recovery and their associated support structures (See White & Kurtz, 2005)
- Is capable of initiating and sustaining healthy, respectful (non-exploitive) recovery support relationships
- Is able to work from a position of collaboration and mutual respect with other service professionals
- Has good self-care rituals and the ability to ask for and utilize supervisory guidance.

Service Procedures and Guidelines: There are several sources that detail the clinical protocol used to conduct post-treatment monitoring, support and early re-intervention. The best of these resources have manualized their procedures to enhance model fidelity. Procedures involved in providing assertive continuing care to adolescents are outlined in:

Godley, S. H., Godley, M. D., Karvinen, T., & Slown, L. L. (2001). *The Assertive Aftercare Protocol: A Case Manager's Manual for Working with Adolescents after Residential Treatment of Alcohol and other Substance Use Disorders*. Bloomington, IL: Lighthouse Institute.

Procedures for post-treatment monitoring and support are outlined in:

McKay, J. R., Feeley, M., & Annis, H. M. (1993). *Manual for Individualized Relapse Prevention Aftercare*. Philadelphia, PA: University of Pennsylvania.

Loveland, D., and Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*. Peoria, IL: Fayette Companies (www.bhrm.org/guidelines/Recovery%20Coach%20and%20Recovery%20Planning%20Manual.doc).

Procedures used to conduct recovery management checkups are detailed in:

Dennis. M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352.

Procedures for conducting telephone-based continuing care are outlined in:

McKay, J. R., Lynch, K. G., Shephard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry, 62*(2), 199-207.

Implementation Issues, Obstacles and Strategies: The obstacles to implementing more assertive systems of post-treatment monitoring and support, in particular models of P-BRSS, are substantial. Such obstacles are:

- conceptual (failure to see the need for P-BRSS services; conflicts between the P-BRSS emphasis on the ecology of recovery / recovery community building and traditional biopsychological models of problem intervention),
- emotional (failure of traditionally-trained professionals to accept P-BRSS service specialists as legitimate professional peers),
- technical (lack of empirical models of P-BRSS and P-BRSS implementation protocol),
- organizational (e.g., weak infrastructures reflected in high staff turnover)
- administrative (challenges complying with treatment-oriented licensing and reporting procedures), and
- fiscal (lack of financing models for P-BRSS; financing systems that pay for repeated episodes of expensive acute care but won't pay for sustained low cost monitoring and recovery support services) (White, 2004b).

The good news is that experiments with professional and peer-based recovery support services are underway across the country and are generating a body of knowledge about how to negotiate rule exceptions from funding and regulatory authorities, new support protocol, models for hiring, training and supervising recovery coaches, and other advances that are laying the foundation for a new model of sustained recovery management.

Representative Studies of the Intervention:

Several recent studies have confirmed the value of more assertive and sustained models of post-treatment monitoring and support.

Godley, Godley, Dennis, Funk & Passetti (2002) randomly assigned 114 adolescents discharged from IP Tx randomly assigned to aftercare as usual (aftercare groups) or assertive continuing care (ACC) (home visits, sessions for adolescents, parents and joint sessions, case management). They found that the ACC group had a higher engagement/retention rate (94%), averaged more than twice the continuing care sessions as the control group, exhibited lower relapse rates for alcohol and cannabis, and, for those who did use, more days to first use.

Dennis, Scott and Funk (2003) tested the effects of a quarterly Recovery Management Checkup (RMC) model over a two-year period with a group of clients entering a central intake unit in Chicago. These clients brought many risk factors for post-treatment relapse, e.g., psychiatric co-morbidity (77%), substance use by others in the home (40%), regular substance use by peers (84%), and history of homelessness (54%). A total of 448 clients (59% female; 85% African American; primarily dependent upon cocaine, opiates and alcohol) were randomly assigned to the recovery management checkup (RMC) protocol or a control condition. Those in the RMC group were interviewed quarterly and, when determined to be in need of treatment, were provided a Linkage Manager who conducted a motivational interview and assisted with re-entry into treatment. The control group received only quarterly interviews but no active linkage to treatment. The study found that those clients assigned to RMC were more likely than those in the control group to return to treatment, to return to treatment sooner, and to spend more subsequent days in treatment. RMC participants also experienced significantly fewer total quarters in need of treatment and were less likely to need treatment 2 years after intake. This experimental evaluation of RMC offers support for three specific elements of the larger model of recovery management – monitoring, motivational interviewing and linkage assistance.

McKay, Lynch, Shephard, and Pettinati (2005) tested the effectiveness of telephone-based, post-treatment monitoring and found that weekly 15-20 minute calls with a counselor maintained treatment gains in all but about 20% of clients—the latter constituting those with the highest problem severity. Telephone-based monitoring may be a very cost-effective and clinically effective monitoring and support tool for all but the most severe substance use disorders.

Limitations and Contraindications:

White, Boyle, and Loveland, in their overview of the recovery management model (2003), caution against the misapplication of this model to individuals with lower problem severity and high recovery capital who may not need sustained monitoring and support to achieve stable recovery initiation and maintenance. They are particularly concerned about the potential misapplication of this model to individuals (e.g., many adolescents) who are likely to resolve alcohol and other drug problems through professional maturation or brief professional intervention. The concern is that entrapping such individuals within a chronic care model could inadvertently do harm via stigma and enmeshment in an unnecessary and potentially expensive service career.

RM models may prove to be most beneficial for those individuals who present with the highest problem severity (high severity substance dependence), problem complexity (medical and psychiatric co-morbidity), and lowest recovery capital (internal and external assets for recovery initiation and maintenance).

Other Key Resources:

For general information on Recovery Management
See www.BHRM.org
See Recovery Management Monograph at www.glattc.org
See IRETA/NEATTC

For specific questions on recovery management
Bill White (bwhite@chestnut.org)
Mike Boyle (MBoyle@fayettecompanies.org)

For information about linking clients to recovery mutual aid groups
See the Mutual Support Resources Guide that is posted at the Faces and Voices of Recovery (FaVoR) Web Site (http://facesandvoicesofrecovery.org/resources/support_home.php) and updated monthly by its developers, Drs. Ernie and Linda Kurtz.

For questions on Assertive Continuing Care procedures with adolescents
Dr. Mark Godley (mgodley@chestnut,org)
Dr. Susan Godley (sgodley@chestnut.org)

For questions on Recovery Management Checkup procedures with adults
Dr. Christy Scott (cscott@chestnut.org)
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About the Author: William L. White, M.A., is a Senior Research Consultant at the Lighthouse Institute, the research division of Chestnut Health Systems. He has worked full time in the addictions field since 1969 and has published more than 220 articles/monographs and eleven books.

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Post-treatment support entails several critical components: 1) stage appropriate recovery education and coaching (feedback and advice), 2) assertive linkage to communities of recovery, 3) problem-solving consultation related to personal and environmental obstacles to recovery (including linkage to broader rehabilitation resources in the community), and 4) on-going assistance in building "recovery capital" (Granfield and Cloud, 1999) via reconstruction of personal identity and a sobriety-based social network.

Post-treatment early re-intervention is the process through which an individual experiencing vulnerability for or experience of a lapse or relapse is provided an intensification of monitoring and support, reconnection to indigenous communities of recovery or professional treatment toward the goal of recovery re-stabilization and facilitation of the transition into stable recovery maintenance.

History of the Practice: Addiction has been characterized as a chronic disease for well over two centuries, but it has been most often treated in acute episodes of care resembling treatment for a broken arm or a bacterial infection. This acute care model is characterized by: 1) serial episodes of self-contained, unlinked interventions (brief detoxification and psychosocial stabilization), 2) the expectation that complete and sustained recovery will follow a single episode of care, and 3) minimal resources devoted to post-treatment continuing care. An expert diagnoses and treats the problem. The service relationship ends via "graduation" and "discharge" with a few "aftercare visits," after which the patient is expected to live a sober life without further need of professional assistance.

Efforts to extend care through sustained monitoring and support date to the nineteenth century expectation of sustained correspondence between inebriate asylums and their discharged patients, the establishment of outpatient clinics to provide follow-up for discharged asylum patients, the use of workers who visited discharged patients in their homes, the linkage of discharged patients to recovery mutual aid societies and the establishment of structured aftercare groups (White, 1998). Short-lived efforts to extend treatment support have inevitably dissipated into ever-briefer models of acute intervention.

Modern efforts to extend the effects of treatment have focused on strategies to increase adherence to expectations for client participation in aftercare groups—in short, to increase the act of clients returning to the treatment facility for booster doses of professional support. Strategies that were rigorously tested and proved to increase such participation include behavioral contracting (Ossip, Van-Landingham, Prue & Rychtarik, 1984), using prompts (mailed appointment reminders and telephone reminders) (Gilbert, 1988), combining prompts and feedback (Lash & Blosser, 1999), conducting a brief aftercare orientation meeting (Lash & Dillard, 1996), and having the client participate in aftercare groups while in inpatient treatment

(Vernis & Taylor, 1994). Home-based aftercare visits were also found to be effective in enhancing recovery outcomes (Gilbert, 1988). Studies of continuing care interventions using behavioral (contingency) contracting, family involvement, case management, couples relapse prevention groups, and the community reinforcement approach also showed promise (Donovan, 1998; Godley, et al., 2002). In spite of their apparent effectiveness, these strategies never became part of mainstream clinical practice in addiction treatment. Most of these proposed enhancements constitute an effort to extend the service dose within the acute care model.

This acute care model of intervention is being challenged by a growing call for models of sustained recovery management. This latter approach emphasizes the similarities between addiction and other chronic health problems, calls for a shift in emphasis from recovery initiation to recovery maintenance, and wraps traditional treatment in a more extended continuum of recovery management support services and monitoring across episodes of care ((McLellan, Lewis, O'Brien, and Kleber, 2000; White, Boyle, Loveland, 2003).

The development and evaluation of protocol for post-treatment monitoring, support and early re-intervention is part of this broader shift toward sustained recovery management. This shift is being pushed by both recovery advocates seeking to reconnect addiction treatment to the larger and more prolonged process of addiction recovery and by a growing body of scientific studies pointing out the limitations of the acute care model. Those limitations include (See White 2004c for data references):

- Limited attraction Less than 10% of those meeting DSM-IV criteria for a substance use disorder seek treatment each year and those who do often confront and then drop out of waiting list.
- High attrition More than half of clients admitted to addiction treatment do not successfully complete treatment.
- Inadequate treatment dose Many clients received less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.
- Weak linkage to peer-based recovery support groups (Inadequate initial linkage and high early dropout rates are the norm. (Emrick, Tonigan, Montgomery & Little, 1993)
- Absence of continuing care Only 1 in 5 clients actually receive any significant continuing care contact.
- High rates of post-treatment relapse The majority of people discharged from addiction treatment resume AOD use in the year following treatment, 80% of whom resume use within 90 days of discharge.
- High rates of treatment readmission 60% of those admitted to addiction treatment already have one or more prior treatment admissions and 24% have three or more prior admissions.
- Repeated treatments preceding stable remission Most treated individuals who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years. (Dennis, Scott, Funk & Foss, 2005).
- Instability of early recovery The point at which risk of future lifetime relapse drops below 15% is not reached until 4-5 years of sustained remission and longer for those addicted to opiates)
- High post-treatment mortality Long-term follow-up studies of discharged clients reveal high mortality rates related to accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide and homicide.

These stark findings do not mean that addiction treatment has no value. Treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder

following treatment) average about one-third, substance use decreases by an average of 87% following treatment, and substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). Recent studies confirm that addiction treatment outcomes are comparable to treatment outcomes for other chronic health conditions (e.g., type I diabetes, hypertension and asthma) (McLellan, Lewis, O'Brien, & Kleber, 2000). What the literature (See later discussion) and cumulative clinical experience are demonstrating is that addiction careers can be shortened and the stability and quality of recovery enhanced by providing post-treatment monitoring, support, and early re-intervention within a framework of sustained recovery management—an approach comparable to approaches for managing other complex, chronic health problems.

Practitioner Credentials:

At the present time, post-treatment monitoring, support and early re-intervention are being conducted both by persons credentialed by education and training and by persons credentialed by experience via their own addiction and recovery careers. Service models employing the latter are often referred to as peer-based recovery support services (P-BRSS). These models deliver P-BRSS within roles bearing such titles as recovery coach, recovery support specialist, personal recovery assistant, and recovery mentor/guide. Such roles are particularly evident within two new federal initiatives—the Center for Substance Abuse Treatment's Recovery Community Support Program and the White House-initiated Access to Recovery program. There is also a trend toward the integration of recovery coaches into community-based treatment programs (see www.dawnfarm.org/articles/recoverycoach.pdf) and the development of post-treatment recovery coaching as a private business (see http://www.personalrecoveryassistants.com/ and http://www.cocaine-addiction.co.uk/recovery_coaching.htm).

Some of the key traits and areas of knowledge and skill that these programs are seeking in the recovery coaches hired to do post-treatment recovery support services include:

- Possesses credibility as a person of integrity, wisdom and compassion within the communities being served
- Knows how to make things happen even when formal resources appear to be lacking
- Exudes hope
- Possesses a deep knowledge of individual/family addiction and recovery processes
- Has a rich knowledge of the local communities and their recovery support resources
- Is knowledgeable about multiple pathways and styles of addiction recovery and their associated support structures (See White & Kurtz, 2005)
- Is capable of initiating and sustaining healthy, respectful (non-exploitive) recovery support relationships
- Is able to work from a position of collaboration and mutual respect with other service professionals
- Has good self-care rituals and the ability to ask for and utilize supervisory guidance.

Service Procedures and Guidelines: There are several sources that detail the clinical protocol used to conduct post-treatment monitoring, support and early re-intervention. The best of these resources have manualized their procedures to enhance model fidelity. Procedures involved in providing assertive continuing care to adolescents are outlined in:

Godley, S. H., Godley, M. D., Karvinen, T., & Slown, L. L. (2001). *The Assertive Aftercare Protocol: A Case Manager's Manual for Working with Adolescents after Residential Treatment of Alcohol and other Substance Use Disorders*. Bloomington, IL: Lighthouse Institute.

Procedures for post-treatment monitoring and support are outlined in:

McKay, J. R., Feeley, M., & Annis, H. M. (1993). *Manual for Individualized Relapse Prevention Aftercare*. Philadelphia, PA: University of Pennsylvania.

Loveland, D., and Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*. Peoria, IL: Fayette Companies (www.bhrm.org/guidelines/Recovery%20Coach%20and%20Recovery%20Planning%20Manual.doc).

Procedures used to conduct recovery management checkups are detailed in:

Dennis. M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352.

Procedures for conducting telephone-based continuing care are outlined in:

McKay, J. R., Lynch, K. G., Shephard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry, 62*(2), 199-207.

Implementation Issues, Obstacles and Strategies: The obstacles to implementing more assertive systems of post-treatment monitoring and support, in particular models of P-BRSS, are substantial. Such obstacles are:

- conceptual (failure to see the need for P-BRSS services; conflicts between the P-BRSS emphasis on the ecology of recovery / recovery community building and traditional biopsychological models of problem intervention),
- emotional (failure of traditionally-trained professionals to accept P-BRSS service specialists as legitimate professional peers),
- technical (lack of empirical models of P-BRSS and P-BRSS implementation protocol),
- organizational (e.g., weak infrastructures reflected in high staff turnover)
- administrative (challenges complying with treatment-oriented licensing and reporting procedures), and
- fiscal (lack of financing models for P-BRSS; financing systems that pay for repeated episodes of expensive acute care but won't pay for sustained low cost monitoring and recovery support services) (White, 2004b).

The good news is that experiments with professional and peer-based recovery support services are underway across the country and are generating a body of knowledge about how to negotiate rule exceptions from funding and regulatory authorities, new support protocol, models for hiring, training and supervising recovery coaches, and other advances that are laying the foundation for a new model of sustained recovery management.

Representative Studies of the Intervention:

Several recent studies have confirmed the value of more assertive and sustained models of post-treatment monitoring and support.

Godley, Godley, Dennis, Funk & Passetti (2002) randomly assigned 114 adolescents discharged from IP Tx randomly assigned to aftercare as usual (aftercare groups) or assertive continuing care (ACC) (home visits, sessions for adolescents, parents and joint sessions, case management). They found that the ACC group had a higher engagement/retention rate (94%), averaged more than twice the continuing care sessions as the control group, exhibited lower relapse rates for alcohol and cannabis, and, for those who did use, more days to first use.

Dennis, Scott and Funk (2003) tested the effects of a quarterly Recovery Management Checkup (RMC) model over a two-year period with a group of clients entering a central intake unit in Chicago. These clients brought many risk factors for post-treatment relapse, e.g., psychiatric co-morbidity (77%), substance use by others in the home (40%), regular substance use by peers (84%), and history of homelessness (54%). A total of 448 clients (59% female; 85% African American; primarily dependent upon cocaine, opiates and alcohol) were randomly assigned to the recovery management checkup (RMC) protocol or a control condition. Those in the RMC group were interviewed quarterly and, when determined to be in need of treatment, were provided a Linkage Manager who conducted a motivational interview and assisted with re-entry into treatment. The control group received only quarterly interviews but no active linkage to treatment. The study found that those clients assigned to RMC were more likely than those in the control group to return to treatment, to return to treatment sooner, and to spend more subsequent days in treatment. RMC participants also experienced significantly fewer total quarters in need of treatment and were less likely to need treatment 2 years after intake. This experimental evaluation of RMC offers support for three specific elements of the larger model of recovery management – monitoring, motivational interviewing and linkage assistance.

McKay, Lynch, Shephard, and Pettinati (2005) tested the effectiveness of telephone-based, post-treatment monitoring and found that weekly 15-20 minute calls with a counselor maintained treatment gains in all but about 20% of clients—the latter constituting those with the highest problem severity. Telephone-based monitoring may be a very cost-effective and clinically effective monitoring and support tool for all but the most severe substance use disorders.

Limitations and Contraindications:

White, Boyle, and Loveland, in their overview of the recovery management model (2003), caution against the misapplication of this model to individuals with lower problem severity and high recovery capital who may not need sustained monitoring and support to achieve stable recovery initiation and maintenance. They are particularly concerned about the potential misapplication of this model to individuals (e.g., many adolescents) who are likely to resolve alcohol and other drug problems through professional maturation or brief professional intervention. The concern is that entrapping such individuals within a chronic care model could inadvertently do harm via stigma and enmeshment in an unnecessary and potentially expensive service career.

RM models may prove to be most beneficial for those individuals who present with the highest problem severity (high severity substance dependence), problem complexity (medical and psychiatric co-morbidity), and lowest recovery capital (internal and external assets for recovery initiation and maintenance).

Other Key Resources:

For general information on Recovery Management
See www.BHRM.org
See Recovery Management Monograph at www.glattc.org
See IRETA/NEATTC

For specific questions on recovery management
Bill White (bwhite@chestnut.org)
Mike Boyle (MBoyle@fayettecompanies.org)

For information about linking clients to recovery mutual aid groups
See the Mutual Support Resources Guide that is posted at the Faces and Voices of Recovery (FaVoR) Web Site (http://facesandvoicesofrecovery.org/resources/support_home.php) and updated monthly by its developers, Drs. Ernie and Linda Kurtz.

For questions on Assertive Continuing Care procedures with adolescents
Dr. Mark Godley (mgodley@chestnut,org)
Dr. Susan Godley (sgodley@chestnut.org)

For questions on Recovery Management Checkup procedures with adults
Dr. Christy Scott (cscott@chestnut.org)
Dr. Mike Dennis (mdennis@chesnut,org)

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2006) *Publishing Addiction Science: A new and valuable resource*. Alcoholism Treatment Quarterly. 24(4), 157-158. Posted at **www.williamwhitepapers.com**

Babor, T. F., Stenius. K. & Savva, S. (Eds.) (2004). *Publishing Addiction Science: A Guide for the Perplexed*. International Society of Addiction Journal Editors.

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This past year has brought an important new resource for researchers and clinicians who wish to publish their work in the peer-reviewed, scientific journals that focus on addiction, addiction treatment or addiction-related social policy. The World Health Organization and the International Society of Addiction Journal Editors have given the addictions field the first definitive guide to addictions-focused scientific journals. *Publishing Addiction Science: A Guide for the Perplexed*, edited by Thomas Babor, Kertsin Stenius and Susan Savva (2004), provides clear guidance on writing, submitting and revising articles as well as a directory of the major journals, the scope of their interests and submission guidelines. For those who have long wished for a Bible of addiction publishing, it has arrived.

Until now, formal guidance on addiction publishing has been limited. Historically, one pursued this venture through a process of professional osmosis—absorbing the nuances of such writing either by imitation or working as an apprentice under the tutelage of more experienced researchers. Some were also coaxed through the publishing process, sometimes painfully, by the critiques that referees levied upon their submitted articles. As a whole, this process was perplexing, even to those with many publications to their credit.

Publishing Addiction Science makes two significant contributions to the addictions field. First, it provides detailed instructions on how scientific articles should be prepared for publication in the best addiction journals. Second, it offers a comprehensive catalogue of the peer-reviewed journals in which such articles can be published. The chapters in this guide are well written and extremely practical. They address such questions as how to choose the best journal to submit your work, how to make authorship decisions (an important discussion given the trend toward multiple authorship), how to properly handle and avoid mishandling citations and how to respond to referee comments and suggestions. Particularly insightful and helpful are a chapter on “the seven deadly sins in scientific publishing” and a chapter on the ethics of writing addiction science.

I suspect *Publishing Addiction Science* will trigger two reactions among most of its readers: gratitude and guilt. The former will come from the comprehensiveness and usefulness of the guidance offered. The latter will come from the self-evaluation that the book inevitably stirs. It is hard to read this book without reflecting on one's own past publishing miscues (from giving or receiving "gift authorship" through unnecessary self-citation to more serious breaches of scientific etiquette and ethics). I finished this book pondering how much my own writing would have been elevated if this resource had arrived at the beginning of my career rather than near its end. I envy the young researchers who will have this work as a foundation upon which to build their publishing careers. I suspect this guide will be integrated into all addiction studies programs and fill a special spot on the desk of most addiction scientists.

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Recovery across the Life Cycle

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Abstract

There is a growing body of literature on addiction recovery, but the effects of age of recovery initiation on the prospects and patterns of addiction recovery remain relatively unexplored. The purpose of this article is to explore the prevalence of, and the qualitative differences in, addiction recovery across the developmental life cycle. The review will include the influence of age of recovery initiation on differences in recovery pathways, styles of recovery, developmental stages and recovery stability.

Key Words: alcoholism, addiction, age, life cycle, early onset, late onset

Introduction

Addiction-related scholarship has historically been either pathology-focused or intervention-focused. Only recently, has there been focused attention on the study of individuals who have achieved long-term resolution of alcohol and other drug problems. The pursuit of a recovery research agenda holds great promise, but the sheer volume of questions to be answered regarding the processes of recovery initiation, consolidation, and maintenance is quite daunting (White, 2004). One sphere of such questions involves the effects of age of recovery initiation on the prospects and processes of addiction recovery. This article discusses what is currently known about recovery and developmental age and identifies key issues for continued research in this area. The article addresses the role of age of recovery initiation on the prospects of long-term recovery from alcohol and other drug problems, pathways and styles of long-term recovery, and the durability and quality of long-term recovery.

Age and the Prospects of Recovery

People develop alcohol and other drug (AOD) problems across the developmental life cycle. Two patterns of age-related onset of AOD problems have dominated the history of addiction treatment in the United States. The first pattern is marked by late adolescent onset of drinking, a slow acceleration of alcohol consumption and alcohol-related problems, and a

maturing of those problems into a point of crisis and help-seeking at mid-life. The second pattern was the adolescent onset of narcotic use, the progression of that use to physical dependence, and the rise of opiate-related problems that brought one to treatment during early adulthood. Most of what we know about addiction, treatment and recovery is based on the onset of alcohol and other drug use in mid-to-late adolescence and the flowering of that use into clinical disorders during early adulthood to mid-life (White, 1998). Two new patterns challenge this knowledge base: the early (pre-adolescent) onset of AOD use and subsequent problems and the growth of late-onset AOD-related problems.

Does early age of onset of AOD use and related problems affect the prognosis for long-term recovery? The age of onset of AOD experimentation and regular use has progressively declined (Dennis, Babor, Roebuck, & Donaldson, 2002; Stoltenberg, Hill, Mudd, Blow, & Zucker, 1999; Presley, Meilman, & Lyerla, 1991) for both adolescent males and females (Substance Abuse and Mental Health Services Administration, 1999). Pre-adolescent onset of AOD use is particularly evident in youth entering juvenile justice and addiction treatment facilities (U.S. Department of Justice, 1994). More than 80% of the 600 youth admitted to the recently completed Cannabis Youth Treatment study began regular substance use between the ages of 12 and 14 (Dennis, Titus, et al., 2002). Such early onset has many clinical consequences (White, Godley & Dennis, 2003). The National Longitudinal Alcohol Epidemiological Survey found that the risk of adult alcohol dependence was directly related to age of onset: before age 15 (40%), age 17 (24.5%), ages 18-19 (16.5%), ages 20-22 (10%). The risk of adult alcohol dependence increased an average of 9% for each decreasing year of age of onset (Grant & Dawson, 1997). Similar findings have been found on the relationship of age of onset of use of other drugs on the risk of adult drug dependence (Dennis, Babor, et al, 2002).

In addition to increasing the risk of developing a substance use disorder, early age of onset of regular AOD use is associated with rapid problem development (Kreichbaun & Zering, 2000), greater problem severity and complexity (e.g., psychiatric comorbidity) (National Institute on Alcohol Abuse and Alcoholism, 2003; Arria, Dohey, Mezzich, Bukstein, & Van Thiel, 1995), less social support for subsequent recovery (Sobell, Sobell, Cunningham, & Agrawal, 1998), and poorer treatment outcomes as measured by rates of post-intervention relapse (Keller et al., 1992; Kessler et al., 2001; Chen & Millar, 1998). More studies are needed to confirm this relationship between lowered age of onset and reduced prognosis for long-term recovery and to identify the precise mechanisms that compromise these recovery outcomes (Chou & Pickering, 1992). Several mechanisms could be at work here, e.g., increased biological vulnerability of pre-adolescents to drug effects, developmental deficits resulting from early onset, lack of family/social support contributing both to problem onset and reduced recovery support resources. Those with late adolescent to young adulthood onset of AOD use who go on to develop AOD problems may have better recovery outcomes than those with early onset because of lower cumulative consumption, less psychiatric comorbidity, and greater social supports (Brennan & Moos, 1995; Sobell, et al., 1998).

If the long-term effects of precocious substance experimentation are confirmed by additional studies, the lowered age of onset of substance use may stand as one of the most socially and clinically significant drug trends of the past century. If poorer long-term recovery outcomes are confirmed, identifying the precise mechanisms that increase risks of problem development and compromise recovery outcomes will be crucial to the development of more effective prevention, early intervention and treatment strategies. Isolating those mechanisms and testing strategies for amelioration of their effects is an important research agenda.

Does recovery prognosis for late-onset AOD problems differ from the recovery prognoses for other patterns of onset?

Alcohol consumption declines in adulthood with advancing age, but alcohol exposure remains high (60% of adults between age 60-94 consume alcohol), and heavy drinking is reported in 13% of men and 2% of women over 60. Some 15% of older alcoholics also suffer from concurrent drug dependence (often related to prescribed medication). About two-thirds of older adults who drink heavily are alcoholics who began drinking in adolescence and whose alcohol problems progress into old age. The remaining third are characterized by a lack of risk factors (e.g., family history of alcoholism), a non-problematic relationship with alcohol through early and midlife, and the emergence of identifiable problems and consequences related to drinking late in life (Rigler, 2000).

Sometimes referred to as "late onset alcoholism," these patterns of problematic drinking are spawned by different vulnerabilities: age-related alterations in biological sensitivities to alcohol, self-medication of acute and chronic pain, use of alcohol as a balm for stressful life events (e.g., deaths, separations, retirement), or enmeshment in drinking social groups following retirement. Those elderly persons with shorter heavy drinking histories have better outcomes than those with longer heavy drinking histories (Rigler, 2000; Schutte, Brennan, & Moos, 1994; Atkinson, Tolson, & Tuner, 1990). Somewhat counter-intuitive is the finding that recovery among late-onset heavy drinkers is associated with increased stressors, suggesting that the continued presence of financial and health-related stressors may actually serve to enhance motivation for recovery maintenance (Moos, 1994).

Escalating life expectancies and shorter work lives will exert an unknown effect on the future prevalence of substance use disorders. What is clear is that new patterns of late-onset alcohol problems spring from complex etiological sources, unfold in diverse patterns and seem to respond to different treatment and support strategies. Without further refinements in the treatment of older adults, the misapplication of adult treatment philosophies and techniques may become as marked as the earlier misapplication of such technologies to adolescents. Assuring that this does not occur is an important research and clinical practice agenda.

Does one's prognosis for successful long-term recovery differ depending on the age at which that recovery is initiated (separate from the issue of the age at which problems developed)? There are two emerging bodies of data that shed some light on this question.

The first body of data encompasses outcome studies of adolescent treatment. Some of the key findings of these studies include the following (see Risberg & White, 2003; White, Dennis, & Godley, 2002; Godley, Godley, Dennis, Funk, & Passetti, 2002):

- Many adolescents mature out of substance-related problems in the transition into adult role responsibilities (see later discussion of styles of recovery).
- For other adolescents, substance use develops into a chronic, debilitating disorder, recovery from which is often proceeded by multiple treatment episodes spanning years.
- Most adolescents are precariously balanced between recovery and relapse in the months following treatment. The period of greatest vulnerability for relapse is in the first 30 days following treatment.
- The most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved functioning in the family, school, and community) and reduced substance use (to approximately 50% of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use.
- The stability of recovery is enhanced by post-treatment monitoring and periodic recovery checkups.

One of the most significant findings emerging from adolescent treatment outcome studies is the finding that the earlier the intervention (in terms of age and

months/years of use) with a substance use disorder, the better the clinical outcomes, the shorter the addiction career, and the longer and more stable the recovery career (Risberg & White, 2003).

The second source of information is that collected on treatment/recovery outcomes for older adults. Findings from this data include the following:

- Remission rates for older problem drinkers are comparable to those achieved by younger adults at short term (1-4 years) follow-up (Schutte, Brennan, & Moos, 1994), but older adults have lower remission rates than younger adults at long-term (10 years) follow-up (Schutte, Byrne, Brennan, & Moos, 2001).
- Remission in older problem drinkers is associated with less alcohol use, gender (female), marital status (married), employment status (unemployed), social support (less than that of unremitted drinkers) and presence of depression and acute and chronic health problems (Schutte, Brennan, & Moos, 1994; Schutte, Bryne, Brennan, & Moos, 2001
- Goldman (1983), in a review of the cognitive impairments associated with alcoholism, concluded that most of the enduring deficits related to alcoholism following recovery were associated with older alcoholics with lengthy drinking histories. Most of the studies reviewed by Goldman found that cognitive functioning returned with sustained abstinence. While simple areas of cognitive functioning may be quickly regained in recovery, other areas such as tasks requiring more novel and rapid information processing are the last to return. The differences in findings across studies could well reflect differences in the ages of onset of addiction and recovery.

In summary, existing studies suggest that recovery rates are low among adolescents, increase through adulthood, and then decline in late life. Granfield and Cloud's (1999) concept of *recovery capital* may help interpret these findings. Recovery capital is the amount and quality of resources that one can bring to bear to initiate and sustain recovery from addiction. What most distinguishes adolescents and older adults from adult populations is the failure to have developed sufficient recovery capital among adolescents and the loss of recovery capital among older adults. The adult rehabilitation model that seeks to resolve problems so that prior levels of functioning can be naturally assumed may be inappropriate for both adolescents and older adults. A shift in focus from problem elimination to building recovery capital for these groups might prove highly beneficial in enhancing recovery outcomes.

There is a body of literature of addiction and treatment careers (Frykholm, 1985; Hser, Anglin, Grella, Longshore, & Prendergast, 1997), but no comparable body of literature on recovery careers. A research-generated cartography of addiction recovery could plot the influence of multiple dimensions on the prospects and processes of long-term recovery, including the influences of age of problem onset and the age of recovery initiation.

Styles and Pathways of Recovery

Are there qualitative differences in the process of recovery initiation across the life cycle? There is a growing body of literature describing the varieties of recovery experience.

Incremental versus Climactic Change Recovery from alcohol and other drug problems may be achieved through a process of incremental change over a considerable period of time (Prochaska, Norcross, & DiClemente, 1994), or by a sudden, life-transforming experience that is unplanned, vivid, positive and permanent (Miller & C'de Baca, 2001). Variations in such styles across the life cycle have not been rigorously evaluated. Early studies of conversion-like transformations of personal identity noted that most such climactic experiences occurred during the adolescent

years (Starbuck, 1901; James, 1902/1985), but modern studies of sobriety-inducing transformative change find such experiences happening primarily in adulthood (Loder, 1989; Miller & C'de Baca, 2001). In short, we know very little about differences in patterns of recovery initiation across the developmental life cycle.

Abstinence-based Recovery versus Moderated Recovery (Problem Resolution) There is evidence that individuals resolve AOD problems through a variety of styles:

- Complete and enduring abstinence from those psychoactive substances previously associated with life problems with the substitution of other secondary drugs (e.g., alcohol, cannabis, caffeine) at sub-clinical levels (moderated use that does not meet DSM-IV criteria for substance abuse or substance dependence).
- Complete and enduring abstinence from all traditional "drugs of abuse."
- Deceleration of AOD use to sub-clinical levels.
- Prolonged abstinence followed by initiation of sub-clinical levels of AOD use (White, 1996).

There is further evidence that the viability of these strategies differs considerably across the categories of personal vulnerability (e.g., family history of AOD problems), problem severity, problem complexity, and family and social supports. What is not clear is the prevalence of these styles across age groups and the degree to which shifts in these styles can occur over time in the same individuals. Many adolescents shift from use to non-use or from problematic to non-problematic use as they move through their teens and twenties into their thirties (Chen & Kandel, 1995), but the cultural stand of "zero tolerance" towards adolescent AOD use makes even the acknowledgement of this latter potential a "third rail" issue often avoided because of the potential damage to one's professional career.

There is evidence that some elderly people with alcohol-related problems resolve such problems by reducing the frequency, intensity and circumstances of their drinking (Heather & Robertson, 1983). In a 16-20 year treatment follow-up study, Nordstrom and Berglund (1987) found that active alcohol dependence declined and stable recovery (defined as sustained abstinence or sub-clinical social drinking) increased over time. As for transitions in recovery style, they found that 40% of the sample initially abstinent in the first six years following treatment later consumed alcohol at subclinical levels (no longer meeting diagnostic criteria for abuse or dependence) during the second decade of follow- up. In a ten-year follow-up study of older problem drinkers, Schutte and colleagues (2003) found that 63% of former problem drinkers were consuming alcohol without identifiable problems. The majority of this non-abstinent remission group did not have severe problem drinking histories. In a sixty-year follow-up of alcoholic men, Vaillant (2003) found 32% of his original sample abstinent and only 1% who had sustained controlled drinking. The differences in the two studies suggests that the likelihood of successful controlled drinking among older former problem drinkers declines in relationship to the severity of their original drinking problem, a finding consistent with earlier research (Hermos, Locastro, Glynn, Bouchard, & Labry, 1988). The most frequent patterns in the Vaillant (2003) study were the movement from problem drinking to abstinence and the movement from problem drinking to experiments with controlled drinking followed by abstinence.

The findings of a 33-year follow-up study of heroin addicts (Hser, Hoffman, Grella, & Anglin, 2001) challenges the theory of an inevitable age-related maturing out of drug problems. Hser and her colleagues found very stable patterns of heroin use over more than three decades. While many of those studied had achieved some periods of abstinence, only 46% were able to achieve five years of abstinence within the 33-year period studied, and the group as a whole showed high past-year rates for multiple drugs (heroin, 40.5%; marijuana, 35.5%; cocaine, 19.4%; and daily alcohol use,

21.1%). These findings suggest that addiction can span the aging process and constitute a lifelong condition. Recovery is not an inevitable product of aging.

Treatment-assisted versus Natural Recovery Most people with AOD problems do not seek treatment and most people who resolve such problems do so without treatment (Cunningham, Sobell, Sobell, & Kapur, 1995; Cunningham, Koski-Jannes, & Toneatto, 1999). There is a growing body of literature on this self-managed style of problem resolution known as natural recovery. A pattern of age-related "maturing out" of narcotic addiction was first described by Winick in 1962. Winick theorized that a maturation process within the life cycle of addiction led to cessation of drug use without intervention in a large portion of addicts. Subsequent studies confirmed that drug cessation increased with age but at a much lower rate than that predicted by Winick (Vaillant, 1966; Snow, 1973). Simpson and Sells (1990) found that opiate use did not cease simply as a function of age, but instead required an accumulation of consequences or a loss of energy required to sustain the opiate lifestyle.

In their review of 38 studies of natural recovery, Sobell, Ellingstad, and Sobell (2000) found two age-related patterns of natural recovery: 1) a young adult pattern of recovery associated with maturation and the assumption of adult role responsibilities, and 2) a later-life pattern of recovery associated with cumulative consequences of alcohol and other drug use. Natural resolution of alcohol problems in young adults is associated with getting married, remaining married, and becoming a parent; the failure to achieve natural resolution is associated with selection of and participation in a heavy-drinking social network (Labouvie, 1996). Those successful in natural recovery are also reported in some studies to be younger and to have had shorter duration of AOD problems than those with treatment-assisted recovery (Cunningham, et al., 1995; Saunders, Phil, & Kershaw, 1979). Studies of older problem drinkers note that more than 70% resolve their drinking problems without professional help (Schutte, Nichols, Brennan, & Moos, 2003).

Fillmore and colleagues (1988) found age-related differences in the factors promoting natural recovery. They found that natural recovery among late adolescents and young adults occurred primarily due to a shift in group norms, whereas maturing out of middle-age drinking problems was much more linked to individual life events. In the latter category, remission in the 30s and 40s was often attributed to the influence of spouse or friends, where remission after that was more likely to be associated with concerns about health. Watson and Sher (1998) noted in their review of the natural recovery literature that adults with late onset alcoholism were more likely to achieve natural recovery than were those older adults with early onset alcoholism (See also Atkinson, et al., 1990). Age -related maturing out may differ among African Americans and Hispanics who are more likely to develop alcohol problems later in life. There is also evidence of gender differences in age-related remission patterns, with men achieving remission at higher rates than women from the late 20s to the mid-40s and women achieving higher rates of remission than men after the mid-40s (Fillmore, Hartka, Johnstone, Speiglman, & Temple, 1988).

Recovery and Personal Identity Persons who resolve AOD problems may do so with a pro-recovery (defining themselves as an "alcoholic"/"addict" in "recovery") or recovery-neutral identity (defining AOD problems in terms of a transient experience rather than in terms of their identity) (White, 1996). The degree to which such styles vary by age of recovery initiation has not been scientifically studied, but one would suspect such variations for adolescent-initiated recoveries and for recoveries initiated among older adults.

Peer-supported Recovery versus Solo Recovery Persons with AOD problems may resolve these problems with active support from other recovering people or with little or no contact with recovering people (White, 1996). Participation in mutual aid groups is associated with enhanced recovery rates (Emrick, Tonigan,

Montgomery, & Little, 1993; Humphreys, Wing, McCarty, Chappel, Gallant, Haberle, et al, 2004). Such participation produces an additive effect to professional treatment of AOD problems (Fiorentine & Hillhouse, 2000), but these effects are limited by failure to affiliate with mutual aid groups such as Alcoholics Anonymous and Narcotics Anonymous following treatment and high dropout rates following initial exposure (See McIntyre, 2000 for a detailed analysis; Mäkelä, et al, 1996; Kelly & Moss, 2003). There is little data on differences in recovery mutual aid group affiliation rates by age. There are studies confirming that adolescent participation in recovery mutual aid groups is associated with improved recovery outcomes following treatment (Johnson & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000; Kelly, Myers, & Brown, 2002), but this finding is tempered by reports that failure to affiliate and high attrition rates following exposure to self-help groups is the norm among adolescents (Godley & Payton, in press). A recent membership survey of AA noted that 2% of AA members were under age 21 and that 13% of AA members were aged 61 or over (Alcoholics Anonymous, 1999). There are reports of attrition of older AA members due to the influx of younger members with different lifestyles and drug choices (Chappel, 1993). McIntyre (2000) also notes that many AA members stop regularly attending meetings after achieving stable sobriety, although they continue to see themselves as AA members and may attend occasional AA celebrations.

Studies finding that self-help participation increases in the months immediately following treatment but then rapidly erodes—from 71% to 43% in one recent study of adults (Kissin, McLeod, & McKay, 2003)—have yet to be replicated in multiple studies with populations of adolescents and older adults. Studies have confirmed that intensity of self-help participation (e.g., number of meetings, having a sponsor, sponsoring others, reading program literature, etc.) enhances recovery outcomes (Montgomery, Miller and Tonigan, 1995; Humphreys, Moos and Cohen, 1997). This intensity of mutual aid involvement has been found in at least one study to apply to adolescents as well as adults (Margolis, Kilpatrick, and Mooney, 2000). The author could find no studies that measured the effect of intensity of participation on recovery outcomes specifically for older adults. The role of age in such affiliation and attrition processes and the effects of intensity of self-help participation among adolescents and older adults deserve serious investigation.

Quality and Durability of Recovery

Recovery and Global Health The term recovery spans removal of drugs from an otherwise unchanged life to a complete and positive transformation of one's character, identity and lifestyle. This broader transformation has been referred to as *emotional sobriety* (Wilson, 1953) or *wellbriety* (Coyhis, 1999). While there is growing interest in measuring these broader changes in personal identity, physical and emotional health, personal relationships, and social and occupational functioning, research has yet to fully illuminate transformations in global health over time in recovery and the differences in the degree of such changes based on the age of recovery initiation.

The short time periods of treatment follow-up and the lack of longitudinal studies of untreated populations in long-term recovery have provided us with only anecdotal reports on these larger dimensions of health in the later stages of recovery. Such studies could be revealing. For example, it is quite possible that the risk factors that contribute to early onset AOD use, the failure to master major developmental tasks due to early onset AOD use, and the lack of resulting "recovery capital" might not only diminish one's prospects of recovery but also substantially compromise the quality of recovery for those who achieve this status. The resulting higher rates of relapse and failure to achieve personal, relational and occupational health might require considerably different post-treatment monitoring and support strategies

compared to that needed for those with later onset of AOD use. Similarly, the successful treatment of late-onset AOD problems might require a much greater focus on achieving global health rather than a more restrictive focus on the elimination of AOD use.

Recovery Durability When is recovery stable (point at which the probability of future lifetime relapse is very low)? The alcoholism literature suggests that persons who reach the 4-5 year window of sustained sobriety have a low (under 15%) risk for future relapse in their lifetime (De Soto, O'Donnel, & De Soto 1989; Dawson, 1996; Jin, Rourke, Patterson, Taylor, & Grant, 1998). Studies on such stability in recovery from addiction to drugs other than alcohol are less definitive and focus primarily on post-treatment follow-up of heroin addiction. In a twelve-year follow-up study of individuals treated for heroin addiction, Simpson, Joe, Lehman, & Sells (1986) found a low (19%) rate of future relapse after three years of cessation of daily heroin use. The fragileness of recovery from opiate addiction is indicated by other long-term follow-up studies reporting that 20-25% of those who achieve five or more years of abstinence from heroin later returned to opiate use (Simpson & Marsh, 1986; Hser, et al., 2001). A recent study by Scott, Foss, and Dennis (in press) indicated that 83% of 1,326 clients followed up quarterly after discharge from addiction treatment experienced one or more recovery/relapse status transition over the three years of follow-up. Additional studies are required to determine if such recovery status volatility is greater or less for adolescents and older adults and whether these populations would benefit from more assertive models of post-treatment monitoring and support, active linkage to age-appropriate recovery support groups, and, when needed, early re-intervention.

Summary

This article has highlighted some of the literature on effects of age on the prospects and patterns of recovery from alcohol- and other drug-related problems. There appear to be significant differences in early- and late-onset substance use disorders, and available data suggests differences based on the age of recovery initiation. The emerging recovery research agenda should include focused attention on: 1) the influence of age of problem development upon the prospects for long-term recovery, 2) differences in pathways and styles of recovery across the developmental life cycle, and 3) the effects of age in interaction with other significant factors (e.g., gender, ethnicity, drug choice) on recovery processes. That knowledge base will lay the foundation for specialized approaches to treatment and recovery support for our youngest and oldest service consumers.

Acknowledgement: Support for this article was provided by grants from the National Institute on Drug Abuse (Grants R01 DA15523, R01 DA014409, R01 DA015133) and the Illinois Department of Human Services (Office of Alcoholism and Substance Abuse Services) via the Behavioral Health Recovery Management project. The opinions expressed here are those of the author and do not reflect the opinions or policies of these agencies.

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Citation: White, W., Sanders, M. & Sanders, T. (2006). Addiction in the African American Community: The Recovery Legacies of Frederick Douglass and Malcolm X. *Counselor*, 7(5), 53-58. Posted at **www.williamwhitepapers.com**

Addiction in the African American Community: The Recovery Legacies of Frederick Douglass and Malcolm X

William L. White. Mark Sanders and Tanya Sanders

Abstinence-based cultural and religious revitalization movements constitute vibrant responses to the rise of alcohol and other drug problems in communities of color. Such movements often inspire culturally nuanced approaches to addiction treatment and provide culturally legitimate pathways of long-term recovery. The spark that ignites such movements is often a charismatic, recovering individual who uses his or her own personal transformation as a springboard for broad social change. This article explores what the lives of two remarkable human beings—Frederick Douglass and El Hajj Malik el Shabazz (Malcolm X)—can teach us about addiction recovery within African American communities.

A Tale of Two Men

Frederick Douglass (1818-1895) escaped slavery to become an internationally recognized orator, author (*Narrative of the Life of an American Slave*), newspaper editor, and skilled social reformer and statesman. He was the dominant force in the political drive to emancipate American slaves and was also a prominent advocate within the temperance and women's rights movements. The character of the man is illustrated in his response to a group of armed men who entered his newspaper office and threatened to destroy his presses. Douglass told his would-be attackers that they could assault him but that other voices would take his place. He boldly offered to help the men and struck one of his own printing presses saying, "You can smash machines, but you can't smash ideas." Stunned by his actions and words, the men left. Frederick Douglass' life offers vivid testimony of how a single individual's unwavering commitment and personal charisma can transform the world.

The life of Malcolm Little (1925 -1965) could be told in serial identities: 1) one of eleven poor children raised on dandelion greens and cornmeal mush; 2) the young boy castigated as "Milky" and "Snowflake" for his light skin; 3) a child bereaved by his father's death and his mother's institutionalization for mental illness; 4) a young man's transition from shining shoes to the street hustling, dope dealing "Detroit Red"; 5) the prisoner known as "Satan" for his animosity toward religion; 6) the minister Malcolm X whose fiery words challenged both blacks and whites; and 7) El Hajj Malik el Shabazz, assassinated in 1965 following

his break with the Nation of Islam and his founding of the Organization of Afro-American Unity. Ossie Davis conveyed something of what Malcolm X meant to the African American community when he eulogized him: "Malcolm was our manhood, our living, black manhood….Our own black shining prince!"

Addiction and Recovery Histories

Most readers of *Counselor* know something of the lives of these two men but may be unaware of the addiction and recovery stories that are part of the larger lives of Frederick Douglass and Malcolm X. Both men were discrete about their addiction histories and the means of their recoveries, but this part of their lives is revealed in their autobiographies, published speeches and archived correspondence.

Douglass spoke most candidly about his early drinking excesses in speeches he gave in Scotland in 1846.

> *I used to love drink—That's a fact. I found in me all those characteristics leading to drunkenness.* (February 18, 1846 Speech in Glascow, Scotland)

> *I have had some experience with intemperance… I knew once what it was like to drink with all the ardour of an old soaker [drunkard]…. Some of the slaves were not able to drink their share [portions of alcohol provided by the slave master], but I was able to drink my own and theirs too. I took it because it made me feel I was a great man.* (March 40, 1846 Speech in Paisley, Scotland)

Douglass told his Glascow audience "…it would be an interesting experience if I should tell you how I was cured of intemperance, but I will not go into that matter now." He never revealed those details in his writings or speeches. We do know that he signed a temperance pledge in 1845 in the presence of Father Theobald Mathew (leader of the Irish temperance movement), kept that pledge of sobriety for the remainder of his life, and went on to play a significant role in the "colored temperance movement" (Cheagle, 1969).

A century later, the man who would later be known as Malcolm X supported his drug habit as a drug dealer, pimp and burglar, describing himself as "always high" on marijuana, cocaine, opium and amphetamines (Malcolm X, 1964, pp. 129, 131). In 1946, Malcolm Little, A.K.A. "Detroit Red," was indistinguishable from other Black addicted men entering prison for drug-related crimes. Through his religious conversion in prison, he found a pathway to recovery and a new identity (Malcolm X). That new identity propelled him onto the world stage where his eloquence served as a voice for the voiceless. His defiant recovery from addiction and his unheralded outreach efforts (what he called "fishing for the dead") brought many addicted African Americans their sobriety and dignity. Those achievements were obscured in the larger controversies that surrounded his life.

Addiction and Recovery through an Africentric Lens

Slave Masters carefully controlled the slaves' access to alcohol. Slaves were prohibited from drinking under normal circumstances but encouraged to drink heavily on Saturday nights and holidays. Douglass viewed such controlled promotion of drunkenness (via such rituals as drinking contests) as a way to keep the slave in "a state of perpetual stupidity" and "disgust the slave with his freedom" (February 18, 1846 Glascow Speech).

> *These holidays serve as conductors, or safety valves, to carry off the rebellious spirit of enslaved humanity . . . this mode of treatment* [promoting episodic drunkenness] *is a part of the whole system of fraud and inhumanity of slavery.* (Douglass, 1855, p. 256)

Douglass further noted how the slave master's promotion of drunkenness reduced the risk of slave rebellions.

> *When a slave was drunk, the slave holder had no fear that he would plan an insurrection; no fear that he would escape to the north. It was the sober, thinking slave who was dangerous, and needed the vigilance of his master to keep him a slave* (Douglass, 1855, p. 256).

Douglass challenged African Americans (slave and free) to abstain from drinking as an act of personal emancipation and as a preparatory step for full citizenship. Through his encouragement and example, nineteenth century African Americans generated their own temperance and mutual aid societies that framed a commitment to sobriety as a stairway to freedom. The pledge recommended in the Temperance Tract for Freedman read:

> *Being mercifully redeemed from human slavery, we do pledge ourselves never to be brought into slavery of the bottle, therefore we will not drink the drunkard's drink: whiskey, gin, beer, nor rum, nor anything that makes drunk come* (Cheagle, 1969, p. 29).

A century later, Malcolm X portrayed alcoholism and addiction as part of the continued machinery of African American oppression. He noted how intoxication had become part of the very fabric of Harlem and other Black communities.

> *…almost everyone in Harlem needed some kind of hustle to survive, and needed to stay high in some way to forget what they had to do to survive* (Autobiography, p. 91).

Like Douglass before him, Malcolm X understood that white institutional interests were well served by addiction in the Black community:

> *…black junkies are trying to narcotize themselves against being a black man in the white man's America, but…the black man taking dope is only helping the white man to "prove" that the black man is nothing* (Autobiography, p. 260).

> *The white man wants black men to stay immoral, unclean, and ignorant. As long as we stay in these conditions we will keep on begging him and he will control us* (Autobiography, p. 221).

While Malcolm X viewed addiction as an outgrowth of historical oppression, he angrily denounced African Americans who embraced their victimhood as an excuse for continued self-destruction. For him, the source of African American salvation could be found only in resources inside their own souls and inside their own community.

> *The social philosophy of black nationalism only means that we have to get together and remove…alcoholism, drug addiction, and other evils that are destroying the moral fiber of our community.* (From 'The Ballot or the Bullet' speech, April 4, 1964, Cleveland, Ohio; Malcolm X, 1965))

Malcolm X thought the worst crime America had committed was teaching African Americans to hate themselves, and he saw alcoholism and drug addiction as a direct manifestation of that self-hatred (Goldman, 1994, p. 120). He saw recovery as a side effect of the spiritual transformation and the psychological, economic and political liberation of Black people. He practiced and challenged others to live a clean life—no alcohol, drugs, tobacco, gambling, or extra-marital sex—as a daily act of respect for self, family and community. Like Douglass, Malcolm X saw booze and dope as anesthetics that numbed the pain of cultural oppression and dissipated the potential for political protest and economic self-determination. For him, sobriety was more than an act of personal reformation; it was a political act of resistance—a refusal to embrace racial suicide, an act of

personal/cultural survival and healing. Like recovery leaders before and after, Malcolm X challenged those who had been saved from addiction to return to the "junkie jungle" to salvage those who were still suffering (Autobiography, pp. 261-262).

Legacies: "Cultural Pathways to Recovery"

So what lessons can addiction professionals draw from the lives of these two history-shaping figures? The authors have explored this question with audiences across America and would offer the following reflections.

Historical Trauma, Liberation, and Cultural Healing: Addiction within communities of color is best viewed within the larger historical context of slavery and oppression. Such historical traumas destroy personal identity and hope, erode cultural sources of resilience, and fuel the appetite for anesthesia. Conversely, recovery is best framed within the larger framework of liberation and personal/cultural survival. To be personally and culturally meaningful, the recovery stories of African Americans may have to be nested within their larger history and contemporary experience as a people.

Catalytic Metaphors: To achieve recovery, each addicted individual must find sense-making, life-transforming ideas that abort the rituals of drug use. Such metaphors spark profound breakthroughs in perception of self and the world that in turn lead to dramatic reconstructions of personal identity and interpersonal relationships. Linking AOD use to historical oppression, portraying alcohol and other drugs as weapons of continued oppression, and portraying sobriety as an act of resistance and liberation can serve such a transformative function for some African American clients.

Strength, Meaning and Purpose: African Americans in recovery can draw strength, meaning, and purpose from their individual and collective survival. Questions such as the following can help elicit that experience of meaning and purpose:

1) How were you able to survive to reach this day when so many did not?
2) What is the purpose for which you were spared?
3) What has your life course prepared you to do?
4) What personal/cultural debts need repayment?
5) What special lessons and gifts would you like to share with others?
6) What does your family and community need from you right now?

Strengths-based approaches are well suited for African American clients, particularly when they focus beyond the individual to tap sources of resilience within the family and kinship network, the community and the larger culture. The recoveries of Frederick Douglass and Malcolm X were rooted in commitments that transcended their own self-redemptions. Challenging the notion that "you can only get sober for yourself," their allegiance to a higher calling—liberating African Americans as a people—guided their recovery and sustained them in the face of temptations, challenges to their characters, and death threats.

Recovery Heroes: There is a critical need in communities of color for culturally viable models of addiction recovery. Recovery can be incited by the identification and inspiration that flows from exposure to charismatic recovering figures. The African American community has been denied such role models by media machinery that vividly portrays the stories of African American addiction while withholding the stories of African American recovery. African American celebrities have also failed to face additional stigma that would accompany acknowledgment of their recovery from addiction—a failure that has helped obscure the universal humanity of the recovery experience. However, visible recovery stories are emerging across ethnic cultures. As addiction professionals, we need to be able to place in the hands of each client stories of recovering people with whom he or she can identify.

Recovery and History: Frederick Douglass and Malcolm X made significant historical contributions, not in spite of their addiction and recovery experiences, but because of the depth of meaning and purpose they discovered within their recovery processes. The field needs a definitive history of recovery among African Americans. Such a history will require considerable research as these stories, particularly of those who have faced the greatest stigma (e.g., women; lesbian, gay, bisexual and transgendered people), exist only as fading whispers within the oral histories of African American communities.

A Living History: Recovery and community service in the lives of Frederick Douglass and Malcolm X are not simply interesting historical artifacts. Recovery is an enduring but hidden reality within African American communities—an experience too often closeted in shame and secrecy. African American men and women in recovery live quiet lives of sobriety and productivity in communities across America. It is time we asked a vanguard of such individuals to step forward as living proof of the liberating, transforming power of recovery in the African American community. It is time we celebrated the historical faces and voices of recovery and the contemporary diversity of recovery pathways within African American communities.

Connection to Community: A common thread within the recovery stories of Malcolm X and Frederick Douglass is the reciprocal relationship each experienced with their larger community. Their recoveries drew succor from African American communities just as their recoveries served those communities. The African proverb "I am because we are and we are because I am" suggests asking each client to explore the relationship between recovery and community.

The Power of Service: Both of the men profiled in this article subsumed their personal recovery within a larger call to service. Recovering people constitute a healing force within African American communities that has yet to be fully mobilized. Perhaps it is time that collective call to service was issued.

The Healing Power of Faith: Both Frederick Douglass and Malcolm X drew strength from religious institutions within their communities and framed sobriety within a larger Africentric moral code. Such resources continue to exist today in the form of vibrant, faith-based recovery ministries. Such resources should be viewed as essential partners in our clinical and recovery support work with African American clients.

Cultural Prescriptions

This review suggests ten prescriptions for addiction professionals and recovery support specialists:

- Carry a message of hope (via assertive outreach programs) to those who have yet to witness the transformative power of recovery.
- Align yourself with the survival capacities and strengths of individuals, families, and cultural communities.
- Collaborate with folk healers and local organizations in the design and delivery of culturally nuanced approaches to recovery initiation and maintenance.
- Expose clients to the histories of recovery and contemporary recovery movements within the larger communities with which they identify (via culturally relevant and recovery-focused speakers, books, pamphlets, movies, and art).
- Affirm the legitimacy of nontraditional pathways of recovery (e.g., frameworks such as the Nation of Islam, Free-n-one, One Church One Addict, Celebrate Recovery, Ladies Victorious, African American Survivors Organization)(See Sanders, 2002).
- Recognize that individuals may initiate recovery within one framework (e.g., A.A., N.A.) but then transition to

another framework (the church) to sustain that recovery.
- Portray recovery as a vehicle for liberation, visibility/voice (personhood), and service.
- Invite clients to explore the larger meaning and purpose within their survival and recovery experiences.
- Reach beyond the individual client to enhance recovery for families, neighborhoods, and communities.
- Challenge your clients to embrace sobriety as a contribution to their families, neighborhoods and communities and as their personal contribution to the history of African Americans.

The lives of Frederick Douglass and Malcolm X contain profound lessons about recovery, community, and history. We believe those lessons are applicable to clients of all colors and cultures.

Acknowledgement: We would like to acknowledge the work of John Crowley who first called our attention to Douglass' recovery status in his collection of essays, *The Serpent in the Bottle*. Support for research on this article was provided by the Great Lakes Addiction Technology Transfer Center (funded by the Substance Abuse and Mental Health Services Administration / Center for Substance Abuse Treatment). All opinions expressed here are solely those of the authors.

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RECOVERY

LINKING ADDICTION TREATMENT & COMMUNITIES OF RECOVERY: A PRIMER FOR ADDICTION COUNSELORS AND RECOVERY COACHES

WILLIAM WHITE, MA • ERNEST KURTZ, PhD
SPECIAL PREFACE BY:
CHARLES BISHOP "THE BISHOP OF BOOKS"
AND MICHAEL FLAHERTY, PhD

RECOVERY-RELATED STUDIES
A SELECTED BIBLIOGRAPHY BY WILLIAM WHITE

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William White, MA • Ernest Kurtz, PhD

SPECIAL PREFACE BY:

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Funded by Substance Abuse and Mental Health Services Administration

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This report was supported through funding from the Clark Hagen Trust - PNC grant and the Northeast Technology Transfer Center (NeATTC) under a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). All material appearing in this publication except that taken directly from copyrighted sources is in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors.

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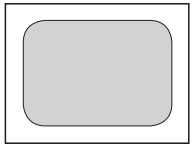

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Preface

This scholarly paper opens the door to real change in the professional addiction treatment community. Addressed to the thousands of counselors and therapists on the daily firing line, it offers them a renaissance of ideas that will provide the suffering addicts with which they work an increased opportunity for lasting recovery.

This paper builds on the "Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates" by William White, MA, and Ernest Kurtz, Ph.D. (2005), and "Building Resiliency, Wellness and Recovery—A Unified Vision for the Prevention and Management of Substance Use Disorders,—A Shift from an Acute Care to a Sustained Care Recovery Management Model," edited (2006) by Michael Flaherty, Ph.D., Executive Director of The Institute for Research, Education and Training on Addictions. The new paradigm expressed in both of these works focuses on an integration of clinical treatment with the recovery movement that exists in every community worldwide.

This paper's most important focus is on recovery and the suffering addict's (client) needs and perspectives as the most important throughout the entire recovery process. This paper emphasizes how each person has both the responsibility for and a philosophy of choice in his/her recovery. Thus, the counselor and clinical treatment system staff become supporting partners along with a rainbow of community-based, non-professional mutual aid recovery fellowships, all working to help the addict.

Herein is a wealth of knowledge based on experience that documents the success of Peer Support (e.g. Alcoholics Anonymous or other fellowships) as the gold standard of mutual aid or recovery fellowships. The Monograph also offers more studies that document increased recovery progress when treatment is combined with such Peer Support fellowships in the community. This work doesn't advocate for treatment alone or recovery support alone as the preferred recovery path. It does make a strong case both academically and experientially that when these approaches are combined the individual receives the greatest opportunity for recovery.

The rebirth of emphasis on recovery recognizes the necessity of cooperation and mutual respect between the recovery and treatment communities. The new recovery coaches and mentors suggested in this paper will augment the roles of traditional therapists and fellowship sponsors. The upgraded professional standards and new language proposed in this paper will challenge not only the professional treatment community, but also governmental agencies, the academic community and credentialing organizations to further evolve in their understanding and work. Further, the paper suggests ways that new financing opportunities could be found to support the proposed integrated recovery model, and the role of using measurable success to propel additional learning and demonstrate required accountability.

The professional addiction treatment field is suffering from major problems involving its depleting work force, its dwindling resources (financial and otherwise), and its lessening supportive, consistent, and recovery sensitive public policies. This paper offers some solutions to these problems—and much needed hope—to the field through its presentation of a new recovery paradigm .

The integration of treatment with the recovery movement depends on recognition and acceptance of some powerful, open-minded, and positive principles: cultural competency, the role of client-chosen spirituality, the many roads to recovery, and the lasting commitment and valuation that our society needs to make for those who need our acceptance and assistance.

So, for the thousands of therapists and counselors out there in the frontline trenches daily trying to help, here's new help. We sincerely thank William White, M.A. and Ernie Kurtz, Ph.D. for their wisdom and guidance. Now, please, read on.

— Charles Bishop, Jr., BA, and Michael Flaherty, Ph.D.

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Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors, Recovery Coaches and the Recovery Community

Introduction

A long-tenured addictions counselor sheepishly shared that he was leaving the field—that it was getting harder and harder for him to feel good about what he was doing. He elaborated as follows, "Something got lost on our way to becoming professionals—maybe our heart. I feel like I'm working in a system today that cares more about a progress note signed by the right color of ink than whether my clients are really making progress toward recovery. I feel like too many treatment organizations have become people and paper processing systems rather than places where people transform their lives. Too much of our time is spent fighting for another day or a couple of extra sessions for our clients. I'm drowning in paper. We're forgetting what this whole thing is about. It's not about days or sessions or about this form or that form, and it's not about dollars; it's about RECOVERY!"[1]

At a recent gathering of Native American leaders, speaker after speaker referenced the disconnection between the world of addiction treatment and the cultural life within Native communities. In their culture, there is no separation between the individual, the family and the tribe. All have suffered wounds from alcohol and other drugs, and all need recovery processes that reflect an understanding of their historical trauma and current circumstances. The speakers advocated healing the community so that the community could in turn serve as a healing sanctuary for individuals and families.

With great sadness, the counselor reflects, "The kids who come here do so well while they are in treatment, but so many of them relapse in the days and weeks following their discharge. We bring them back to treatment and they seem to do well again but often repeat the relapse pattern when they go back home. How can they do so well in treatment and so poorly in their natural environments?"

An A.A. old-timer laments the lost service ethic among local groups in his community and recounts times when Twelve Step calls were something more than telling someone to call the local detox center. He feels that the service ethic weakened in tandem with the expansion of addiction treatment.

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1 Many reviewers responded to this first paragraph just as audiences do around the country when we present this material. As one reviewer noted, "The treatment system across the nation is being strangled in its own red tape."

The growing interest in recovery research, the advent of recovery coaches and recovery support centers and the expanded funding for peer-based recovery support services all reflect efforts to recapture the field's lost recovery focus and reconnect the treatment experience to recovery and treatment institutions to the larger communities in which they are nested. There are increasing calls to shift addiction treatment from ever-briefer episodes of acute stabilization to a more global process of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000). This would extend the role of the addiction counselor beyond the earliest stages of recovery initiation to the more complex processes of recovery stabilization and maintenance within the natural environment of each client and family. A critical aspect of that process involves connecting recovering individuals and families to local recovery support groups and communities of recovery as well as nurturing the development of such supports where they do not yet exist (White, Boyle & Loveland, 2002).

At the same time, many communities of recovery are experiencing a revival in service work as new recovery advocacy groups, in the language of the Connecticut Community of Addiction Recovery, "organize the recovery community's ability to care." Such organizations are acting on the belief that the recovery community has a responsibility to reach out to treatment organizations as well as to individuals and families who are entering and leaving treatment. These recovery advocacy groups are discovering a growing vanguard of people in long-term recovery who are responding with their time, their talents, their financial resources, and, most importantly, their stories to help those whose current suffering was once their own.

This monograph explores how to best facilitate this connection between the worlds of addiction treatment and addiction recovery. It is divided into six topical discussions:

1) The historical forces that are sparking a re-evaluation of the design of addiction treatment in the United States,

2) A review of the scientific evidence supporting the shift from an exclusively acute care (AC) model of treatment to a model of sustained recovery management (RM),

3) The growth, current status and growing diversity of American communities of recovery,

4) Strategies for building relationships between treatment organizations and local communities of recovery,

5) Procedures that can be used to assertively and effectively link clients to recovery support groups, and

6) Integrating this linkage process within a larger menu of post-treatment recovery support services.

This monograph is a follow-up to our recently released monograph, *The Varieties of Recovery Experience* (posted at http//:www.glattc.org). Our work on these recovery-themed papers began in 1998 with the establishment of the Behavioral Health Recovery Management Project funded by the Illinois Department of Alcoholism and

Substance Abuse. Subsequent support has been provided by the Great Lakes Addiction Technology Transfer Center and (for this latest monograph) the Institute for Research, Education and Training in Addictions (IRETA). We extend a special thanks to Dr. Michael Flaherty and Charlie Bishop, Jr. for their guidance on the development of the content of this essay and for their helpful reviews of early drafts. We would also like to thank the following individuals for their helpful feedback and suggestions: Jim Balmer, Ben Bass, Maryanne Frangules, Bev Haberle, Earl Harrison, Maya Hennessey, Martin Nicolaus, Bob Savage, Jason Schwartz, Richard Simonelli, Pat Taylor, Phillip Valentine, and Pam Woll.

A Brief Note on Language

The groups in which people regularly meet for mutual support in their recovery from alcohol and other drug problems have gone by many designations (*self-help, mutual aid, peer support* and *recovery support*). In the following pages, the terms *recovery mutual aid groups* and *recovery support groups* will be used interchangeably to refer to these groups. The larger networks of people and activities in which support group meetings are imbedded are referred to as *communities of recovery*. The term *recovery community* is used to convey the whole of these increasingly diverse communities of recovery. The phrase *recovery support services* refers specifically to non-clinical (not requiring training in diagnosis and treatment) services that aid recovery initiation and maintenance, e.g., activities such as monitoring (check-ups), modeling, sharing, encouraging, coaching/advising, linking, advocating and organizing. *Addiction*, as used in the following pages, is an umbrella term for substance use disorders that are characterized by severity and chronicity. Our choice to use it reflects our belief that severity and chronicity are the best predictors of those who will most need affiliation with communities of recovery to initiate and sustain the recovery process.

A Special Note to Administrators and Supervisors

This monograph is written primarily for those working on the front lines of addiction treatment and recovery, particularly the addiction counselors and recovery coaches who bear responsibility for linking clients to local communities of recovery. We would be remiss, however, if we did not acknowledge the crucial roles administrators and clinical supervisors play in shaping the milieu within which such linkage processes can occur. We hope that as you read these pages you will reflect on what changes in treatment philosophy and service protocol would facilitate this linkage process. We have written earlier papers addressing this question and it is our intent to follow this paper with one focusing specifically on clinical supervision within recovery-oriented systems of care. We invite you to e-mail us in care of the first author (bwhite@chestnut.org) to request copies of those articles or to share your questions, thoughts and suggestions related to what should be addressed within that next paper.

We do want to respond briefly to the question: Who will pay for recovery coaches and for assertive approaches to post-treatment continuing care and recovery support services? We anticipate that financial support for such roles and the reimbursement of post-treatment recovery support services will be a part of the restructuring of addiction treatment from an acute care model to a model of sustained recovery management. Such roles and services are already being financially subsidized through the Center for Substance Abuse Treatment's Recovery Community Support Program and Access to Recovery Program, several state systems (e.g., CT, AZ) and by some managed behavioral health care systems. We anticipate a day soon when it would be unthinkable to provide services designed to initiate addiction recovery without also providing the support services that play such a crucial role in maintaining recovery.

Historical Background: Toward a Recovery Paradigm

From Problem Conceptualization to Treatment Strategies: Cultures across the world have embraced widely divergent views of the origin of alcohol and other drug (AOD) problems. AOD problems and their resolution have been defined in religious terms (sin and redemption), spiritual terms (hunger for meaning and personal transformation), criminal terms (amorality/immorality and reformation), medical/disease terms (sickness and recovery), psychological terms (flawed thinking/coping and maturation), and socio-cultural terms (historical trauma/oppression and liberation/cultural renewal). These highly divergent approaches and their historical roots have been a subject of considerable debate (see Miller & Kurtz, 1994; Kurtz, 2002).

The question of which model is "true" or "works" is not a trivial one. The model choice dictates cultural/professional ownership of AOD problems-whether these problems belong to priests, judges, physicians, psychologists, addiction counselors or community activists. The chosen model dictates particular intervention philosophies and settings (whether the alcoholic is punished in a jail cell or counseled in a treatment center) and offers organizing metaphors for individuals and families impacted by AOD problems. All of the noted models begin with an understanding of the primary cause of AOD problems and then derive resolution strategies congruent with that understanding. This paper, in contrast, asks, "What if addiction treatment, addiction counseling and related recovery support services were designed, not on a particular view of the etiology of addiction, but on the lessons drawn from millions of people who have achieved long-term addiction recovery?"

Treatment, Recovery, Community: Modern addiction treatment came of age in the 1960s and 1970s as a community-based phenomenon. Programs of that era were birthed out of grassroots community advocacy efforts and held accountable to their founding visions through:

- representation of recovered and recovering people and their families on agency boards and advisory committees,
- recruitment of staff from local communities of recovery,
- vibrant recovery volunteer programs, and
- regular meetings between the treatment agency and the service committees of local recovery support fellowships.

Treatment agencies of this era, because of their reliance on local funding, were also accountable to local governments and allied service agencies. Through the processes of professionalization, industrialization and commercialization in the 1980s, most treatment programs ceased being community-based agencies and redefined themselves as businesses. In the process, they became less reliant on local funding, less accountable to local communities and less connected to local communities of recovery. Today, treatment institutions are vulnerable to the charge that they are disconnected from their founding roots-that treatment has

become detached from the larger and more enduring process of recovery and disconnected from the physical and cultural contexts in which that recovery succeeds or fails (White, 2001a; White & Hagen, 2005).

The Varieties of Recovery Experience: Another category of influence on the process of linking people to communities of recovery is the growth and diversification of recovery support societies in the United States and around the world (Humphreys, 2004). The growth, geographical dispersion and longevity of Alcoholics Anonymous (A.A.) have positioned A.A. as the most visible recovery mutual aid fellowship in the United States. That said, there is a growing diversification of styles of Twelve Step recovery experience and a proliferation of explicitly religious and secular alternatives to Twelve Step programs. This growth and diversification of recovery support groups as well as the growing recognition of different styles of recovery initiation and maintenance require a greater level of knowledge and skill for those linking individuals to post-treatment recovery support services (White & Kurtz, 2005). It also requires understanding the difference between linking a client to recovery support meetings and linking a client to the larger community of recovery within which such meetings are imbedded (Balmer, personal communication, 2006).

Emerging Movements: There are two emerging movements that, by their success or failure, will shape the future of addiction treatment and recovery in America. The first is a treatment renewal movement. Led by front line service providers from across the country, the goals of this movement include reconnecting treatment to the process of long-term recovery and rebuilding relationships between treatment organizations, local communities and local recovery support groups (White, 2002). A second movement, the new recovery advocacy movement, rose in reaction to the restigmatization, demedicalization and recriminalization/penalization of AOD problems in the 1980s and 1990s. This movement has been led organizationally by a coalition of the Faces and Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Johnson Institute, the Legal Action Center, and (until recently) the Center for Substance Abuse Treatment's Recovery Community Support Program.[2] The goals of this movement include reaffirming the reality of long-term addiction recovery, celebrating the legitimacy of multiple pathways of recovery, enhancing the variety, availability and quality of local/regional treatment and recovery support services, and transforming existing treatment businesses into "recovery-oriented systems of care" (White, 2000; White & Taylor, in press).

Toward a Recovery Paradigm: Something is shifting in the behavioral health arena. Pathology and intervention paradigms are yielding to an emerging recovery paradigm in both the addictions and mental health fields (White, 2004a, 2005; White, Boyle, Loveland, 2004; Anthony, Gagne, & White, in press). The earliest calls for this reconnection of treatment and recovery came from tenured addictions

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2 In 2002, the Center for Substance Abuse Treatment shifted the philosophy of its Recovery Community Support Program (RCSP) grants from a focus on recovery advocacy to a focus on peer-based recovery support services.

professionals (See Zweben, 1986; Morgan, 1995, a,b; Else, 1999), a new generation of recovery advocates (e.g., Don Coyhis, Bev Haberle, Bob Savage, Philip Valentine), leading research scientists (McLellan, Lewis, O'Brien & Kleber, 2000), and state and federal policy makers (See http://www.dmhas.state.ct.us/recovery.htm and http://alt.samhsa.gov/news/NewsReleases/040303fs_atr_facts.htm).

Implications for the Addictions Counselor and Recovery Coach: For those involved in the face-to-face work of providing addiction counseling and recovery support services, this shift toward a recovery paradigm is pushing a(n):

- greater focus on what happens BEFORE and AFTER primary treatment,
- transition from professional-directed treatment plans to client-developed recovery plans (Borkman, 1997) (See sidebar),
- greater emphasis on the physical, social and cultural environment in which recovery succeeds or fails (e.g., shift from clinic-based aftercare to community-based continuing care) (Donovan, 1998),
- integration of professional treatment and indigenous recovery support groups (White & Sanders, 2004),
- increased use of peer-based recovery coaches (guides, mentors, assistants, support specialists) (White, 2004b), and
- integration of paid recovery coaches and recovery support volunteers within interdisciplinary treatment teams.

HOW RECOVERY PLANS (RP) DIFFER FROM TREATMENT PLANS (TP)

1. The RP is developed, implemented, evaluated and refined by the client, not the treatment professional.
2. The RP is based on a partnership/consultation relationship between professional and client rather than an expert-patient relationship.
3. The RP is broader in scope, encompassing such domains as physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality, in addition to the resolution of AOD problems.
4. The RP consists of a master plan of long-term recovery goals and a weekly action plan of steps that will mark progress toward those goals.
5. The RP emphasizes drawing strength and strategies from the collective experience of others in recovery.

Source: Borkman, T. (1997) Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment 15*(1), 37-42.

This shift to a recovery paradigm is not without its sources of resistance and potential pitfalls. The obstacles that slow this shift are:

- conceptual (difficulty shifting from problem-focused to solution-focused thinking; difficulty thinking outside the acute care intervention model),
- personal/professional (a perceived loss of professional pride/status/power by addiction professionals, hesitancy to acknowledge the experiential wisdom of the recovery community, and reluctance to accept indigenous healers as peers) (Schwartz and Bass, personal communications, 2006),
- financial (the lack of financing models for post-treatment support services),
- technical (lack of evidence-based recovery support service protocol),
- ethical (the absence of ethical codes to guide the delivery of peer-based recovery support services), and
- institutional (weak infrastructures of addiction treatment organizations, particularly the exceptionally high turnover of service roles in the addiction treatment field).

While these obstacles are significant, the greatest obstacle may well turn out to be the tendency for treatment professionals to declare that they are already "recovery-oriented" or to mask treatment as usual behind a new recovery-focused rhetoric.

Working through these obstacles are recovery advocates and visionary professionals who "get it" and are willing to be part of this recovery advocacy and recovery support movement. Some of you reading these words may not fully realize it, but you were born for this moment in time. Your personal and professional experiences to date have prepared you to play a leadership role within this window of opportunity within the history of addiction treatment and recovery in America. It is the hope of the authors that you and others will use our discussions here to develop a personal vision of the role that you could play in widening the doorways of entry into addiction recovery and in enhancing the quality of life of people in recovery.

Scientific Background: Post-Treatment Outcomes, Role of Continuing Care, Role of Recovery Mutual Aid Participation, Importance of Post-Treatment Check-ups and Support

> *If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients.*
>
> — Dr. Tom McLellan, 2002

The shift to a recovery paradigm is propelling the call for non-clinical alternatives to treatment, early identification and recovery engagement services, in-treatment recovery support services to increase successful treatment completion (now only about 50% of those admitted) (SAMHSA, 2002), and post-treatment monitoring and recovery support services. This paper focuses on the latter of these changes. To bolster our argument for post-treatment recovery support services, we offer the following propositions.[3]

The need for post-treatment check-ups and recovery support services intensifies as problem severity increases and recovery capital decreases. (*Recovery capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery) (Granfield & Cloud, 1999). Not everyone with an AOD problem needs professional treatment or prolonged post-treatment continuing care. Many individuals with AOD problems resolve these problems without professional assistance, without involvement in recovery support groups, or through brief professional intervention. Those who require a larger dose, intensity and duration of professional and peer support services to resolve these problems are characterized by greater personal vulnerability (e.g., family history, age of onset, developmental victimization), greater problem severity, greater problem complexity (e.g., presence of co-occurring medical/psychiatric illness), and fewer family and social supports for long-term recovery (White, 2005). The increased representation of clients entering treatment with multiple personal/family/environmental problems (and complex histories of intergenerational transmission of those problems) calls for a longer period of service provision (but not necessarily longer lengths of stay in acute levels of treatment) and an expanded menu of clinical and non-clinical recovery support services.

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3 This is not to say that linkage to recovery communities is something that should occur after *treatment, but we do emphasize the role of such linkages on post-treatment recovery outcomes. We agree with several reviewers suggesting that this linkage could occur at the earliest point of service contact, including people who are on a waiting list for admission to treatment.*

Addiction treatment outcomes are compromised by the lack of sustained recovery support services. Reports of treatment effectiveness note robust effects. Treatment follow-up studies report an average full remission rate of one-third and significant reductions in AOD use/AOD-related problems for most clients (Miller, et al, 2001). Hundreds of thousands of people have entered recovery through the pathway of professional treatment, but claiming that "treatment works" as a result of these findings masks the fact that the majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2003), with over half of all post-treatment lapses and relapses occurring within 30 days of discharge (80% within 90 days of discharge) (Hubbard, Flynn, Craddock & Fletcher, 2001).

Professionally-directed, post-discharge continuing care can enhance recovery outcomes, but only 1 in 5 clients actually receives such care (Ito & Donovan, 1986; Johnson & Herringer, 1993; Godley, Godley, & Dennis, 2001; Dennis, Scott, & Funk, 2003; McKay, 2001). Strategies proven to increase continuing care participation (e.g., the use of a brief orientation session on continuing care, behavioral contracting, telephone prompts) (Lash, 1998; Donovan, 1998) are not mainstream practices in addiction treatment. Nothing conveys more clearly the acute care model of addiction treatment in the United States than the "afterthought" status and virtually non-existent budgets supporting continuing care following "primary treatment." The self-contained, brief episodes of *assess, diagnose, treat, discharge, terminate the service relationship* that typify most addiction treatment would be unthinkable in the treatment of any other chronic medical condition. Addiction professionals do not do assertive post-treatment monitoring and early re-intervention, but there is substantial anecdotal evidence that drug dealers and addicted peers do.

Participating in peer-based recovery support groups following treatment enhances long-term recovery outcomes, but without ancillary support, there is high attrition in such participation among those discharged from treatment (Mäkelä, Arminen, Bloomfield, Eisenbach-Stangl, Bergmark, Kurube, et al., 1996). Overall dropout rates in A.A. range between 35-68%, with most of this attrition occurring in the first weeks and months of contact with A.A. (Emrick, 1989). The two most recent and largest studies of attrition in A.A. participation during the year following discharge from treatment reported 41% and 40% dropout rates (Tonigan, Miller, Chavez, Porter, Worth, Westphal, Carroll, Repa, Martin & Tracy, 2002; Kelly & Moos, 2003). Active linkage (education about the potential value of peer support; facilitating direct connection to a person or specific group) can increase affiliation with a recovery mutual aid society (Weiss, et al., 2000), but studies reveal most referrals from treatment professionals to mutual aid organizations are of the passive variety (verbal suggestion only) (Humphreys, et al., 2004).

At present, the resolution of severe substance use disorders can span years (sometimes decades) and multiple treatment episodes before stable recovery maintenance is achieved (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Hristova, 2002). AOD drug dependencies resemble chronic disorders (e.g., type 2 diabetes mellitus, hypertension and asthma) in

their etiological complexity, variable pattern of onset, prolonged course (with waxing and waning of symptom severity), treatment (sustained management rather than cure), and clinical outcomes (O'Brien & McLellan, 1996; McLellan, et al, 2000). To characterize addiction as a chronic disorder is not to suggest that recovery is not possible. There are millions of people in stable, long-term recovery from addiction (Humphreys, 2004; Dawson, et al, 2005), but the processes of recovery are more complex than what is portrayed to the public and to individuals and families entering treatment.

For many individuals, recovery sustainability is not achieved in the short span of time treatment agencies are currently involved in their lives. When addiction treatment agencies discharge clients following a brief episode of services, they convey the illusion that continued recovery is self-sustainable without further professional support. However, research data reveals that durability of recovery from alcoholism (the point at which risk of future lifetime relapse drops below 15%) is not reached until after 4-5 years of sustained remission (De Soto, O'Donnel, & De Soto, 1989; Jin, Rourke, Patterson, Taylor, & Grant, 1998). This recovery durability point is even longer for recovery from narcotic addiction (Simpson & Marsh, 1986; Hser, Hoffman, Grella, & Anglin, 2001). Such findings beg for models of sustained post-treatment check-ups and support comparable to the assertive post-treatment monitoring used in other chronic disorders, e.g., diabetes, heart disease, cancer. While the effects of acute treatment erode with time, the influence of the post-treatment environment increases. That is the environment we must niche within and remain within if we are truly interested in long-term recovery.

Addiction treatment has become the revolving door it was intended to replace. Addiction treatment was birthed in part to eliminate the "revolving door" through which alcoholics and addicts cycled through the criminal justice system and public hospitals. Addiction treatment programs have now become that revolving door. Today, 64% of persons entering publicly funded treatment in the United States have already had one or more prior treatments (22% with 3-4 prior treatments; 19% with 5 or more prior treatments) (OAS, 2005). Between 25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year, and 50% will be readmitted within 2-5 years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989; Simpson, Joe, & Broome, 2002).

There may be cumulative and synergistic effects resulting from multiple treatment episodes. Long-term studies of clients treated for *substance dependence* in publicly funded programs reveal that the majority of those who achieve stable recovery do so after 3 to 4 episodes of treatment over multiple years (Anglin, Hser, & Grella, 1997; Dennis et al., 2005; Grella & Joshi, 1999; Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Hser, Grella, Chou, & Anglin, 1998). This raises the potential for linking and integrating multiple episodes to enhance their power to facilitate recovery initiation and maintenance. According to studies of clients who relapse following discharge from primary treatment, the best predictor of recovery at five years following discharge is readmission to treatment (Mertens, Weisner & Ray, 2005). We need to find ways to strategically link these episodes of care to shorten addiction careers.

There is a growing body of evidence that enmeshing clients with high problem severity and low recovery capital within sober living communities can dramatically enhance long-term recovery outcomes (Jason, Davis, Ferrari & Bishop, 2001). A just-completed study compared the post-treatment recovery of individuals discharged from addiction treatment who were randomly assigned to either an Oxford House (one of the 1,200 Oxford Houses in the U.S.) or to traditional post-treatment "aftercare" (access to outpatient continuing care groups). The Oxford House members had less than half the rate of substance use, twice the monthly income, and a third of the incarceration rate of those assigned to traditional aftercare (Jason, Olson, Farrari & Lo Sasso, in press). This confirms earlier research on the importance of social support in the recovery process (Jason, Davis, Ferrari & Bishop, 2001; Humphreys, Mankowski, Moos & Finney, 1999) and suggests the need for greater linkage between addiction treatment institutions and this growing network of sober housing resources and sober social communities.

Conclusions:

1. Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months and even years following treatment.

2. Post-treatment check-ups and support and assertive linkage to communities of recovery and other recovery support services can significantly enhance long-term recovery outcomes.

The findings of two recent Chicago studies stand as confirmation of these conclusions. Scott, Foss and Dennis conducted quarterly monitoring interviews of 1,326 clients over three years following an index episode of addiction treatment. Each client was categorized each quarter as 1) in the community using, 2) incarcerated, 3) in treatment, or 4) in the community not using. More than 80% of the clients changed status one or more times over the course of the three years (Scott, Foss & Dennis, 2005). In the second study, Dennis, Scott and Funk (2003) randomly assigned 448 individuals discharged from Chicago addiction treatment facilities to either a recovery management checkup (RMC) group (who received quarterly assessments, motivational interviewing, and, if needed, re-linkage to treatment services) or a control condition (quarterly status assessment only). The study found that those clients assigned to the RMC condition were more likely than those in the control group to return to treatment, to return to treatment sooner, and to spend more subsequent days in treatment. Most significantly, RMC participants experienced significantly fewer total quarters in need of treatment and were less likely to need treatment at 2 years follow-up.

The fragileness of post-treatment adjustment and evidence that multiple treatment episodes can precede stable recovery raise the possibility that addiction and treatment careers could be shortened and recovery careers extended if post-treatment check-ups and support were provided for substance use disorders in

the manner they are being provided for other chronic conditions. In the long run, check-ups and support could:

- decrease the total number of acute treatment episodes required to achieve long-term recovery,
- speed admission when such treatment is needed,
- enhance the dose of treatment and support services received, and
- hasten recovery stabilization and maintenance.

The studies of Dennis, Scott and colleagues (2003) and McKay's (2005) recent review of research on extended interventions confirm the potential importance of post-treatment monitoring (via recovery check-ups and active linkage to recovery supports). There is also evidence that such effects can be achieved using low-cost delivery formats (e.g., telephone-based check-ups and support) (McKay, 2005). The Connecticut Community of Addiction Recovery is currently being funded through the Connecticut Department of Mental Health and Addiction Services to pilot a telephone-based recovery support project for individuals who have been discharged from addiction treatment (Boffman, Fisher, Gilbert & Valentine, in press).

American Communities of Recovery: A Brief Introduction

A Long and Rich History: American recovery mutual aid societies predating A.A. include abstinence-based Native American religious and cultural revitalization movements (from the early 1730s), recovery circles of the Delaware Prophets, Handsome Lake Movements, Shawnee and Kickapoo Prophet movements, Indian Shaker Church, Native American Church and today's Wellbriety Movement, the Washingtonians (1840s), the Fraternal Temperance Societies (1850-1900), the Ribbon Reform Clubs (1870s), institutional support groups such as the Keeley Leagues and the Godwin Association (1870s-1890s), and such faith-based groups as the Drunkard's Club, the United Order of Ex-Boozers and the Jacoby Club (early 20th century) (White, 2001b). The history of A.A. has been marked by progressive growth in membership and groups, a diversification of A.A. member characteristics (by age, gender, ethnicity, sexual orientation, occupational background, etc.), and a growing diversity of styles of recovery within A.A. Adaptations of A.A.'s Twelve Steps began with Alcoholics Victorious (1948) and Narcotics Anonymous (1947, 1953), with alternatives to Twelve Step recovery programs growing rapidly in the last quarter of the twentieth century.

Today, there are explicitly religious, spiritual (but not religious), and secular frameworks of addiction recovery in the U.S. Recovery support groups that emphasize the role of spirituality in recovery are represented by mainstream Twelve Step groups. Faith-based recovery support structures include Alcoholics Victorious, Teen Challenge, Alcoholics for Christ, Overcomers Outreach, Liontamers Anonymous, Mountain Movers, High Ground, Free N' One, Victorious Lady, Celebrate Recovery, Millati Islami and many local recovery ministries. Secular frameworks of recovery include Women for Sobriety (WFS), Secular Organization for Sobriety—Save Our Selves (SOS), Rational Recovery (RR), Men for Sobriety (MFS), Moderation Management (MM), SMART Recovery(r), and LifeRing Secular Recovery (LSR) (White & Kurtz, 2005).

The major addiction recovery support groups are profiled in the Mutual Support Resources Guide that is posted at the Faces & Voices of Recovery website (http://facesandvoicesofrecovery.org/resources/support_home.php) and updated monthly by its developers, Drs. Ernie and Linda Kurtz. The Faces and Voices Guide catalogues group and Internet-based mutual recovery support resources. A summary chart of American addiction recovery mutual aid groups is displayed in Table 1 in the Appendices, profiling each organization's founding date, membership size, philosophical orientation (secular, spiritual, religious), primary support format (face-to-face meetings or Internet-based support), and any special group focus. This table can serve as a tool in matching individuals to particular groups, but the most detailed information and web links to these groups can be found at the Faces and Voices website.

Varieties and Commonalities: Studies of recovery support structures reveal a diversity of catalytic metaphors that individuals use to understand and alter patterns of AOD use/problems. Metaphors are terms or phrases (crystallizations

of ideas) that through analogy have the power to label and elucidate complex experience. Metaphors create breakthroughs in perception that enhance understanding of oneself and the self-world relationship. Catalytic metaphors are words/ideas that are so penetrating that they drive profound changes in personal behavior, personal identity and interpersonal relationships. There is, for example, a long history of the use of medical metaphors to understand addiction, e.g., *disease, illness, allergy.* Such constructs are "true" for many persons in the sense that they validate and make sense of otherwise incomprehensible and sanity-challenging experiences. They are metaphorically true to the extent that they provide a cognitive cornerstone through which some individuals can organize their movement from addiction to recovery via the processes of story reconstruction and storytelling (White, 1996).

The proposition that there are many pathways and styles of recovery rests on the existence of a wide range of words, ideas, metaphors and experiences that can serve as a catalyst for recovery initiation and maintenance. There are, for example, recovery programs that place the transcendence of self at the center of the recovery experience (e.g., A.A.'s powerlessness, acceptance, surrender; being "born again" in Christian recovery frameworks). But there are alternative frameworks that emphasize assertion of self (e.g., Women for Sobriety's "I have a drinking problem but it no longer has me. I am the master of it and I am the master of myself.") (Kirkpatrick, 1986, p. 166.) The variability of these frameworks is also seen when contrasting empowerment psychotherapies with models of alcoholism treatment that have tended to extol the importance of surrender and humility in the recovery process (Tiebout, 1949). Where most recovery frameworks focus on individual experience, frameworks arising within historically disempowered communities often use catalytic metaphors that focus on collective experience (historical trauma, genocide, cultural survival/renewal) as frameworks to understand the etiology of AOD problems and provide a rationale for rejection of alcohol and other drugs (e.g., The Red Road) (Coyhis, 2000).

Core ideas, organizational structures, meeting formats, communication styles, and daily recovery rituals differ considerably across the growing spectrum of American recovery mutual aid groups, but these groups also share many common characteristics. All recovery support groups:

- contain members who have transformed their lives using the group's key ideas and methods,
- provide an esteem-salvaging answer to the question, "Why me?" (How did I come to develop a problem in my relationship with alcohol and/or other drugs?),
- provide a rationale for dramatically altering one's pattern of AOD consumption,
- provide daily prescriptions for recovery maintenance, and
- enmesh each individual in a sanctuary of shared "experience, strength and hope."

A point crucial to this paper is that all recovery support groups have individuals who fully respond to their respective programs of recovery, individuals who partially respond, and individuals who do not respond at all (Morgenstern, Kahler, Frey & Labouvie, 1996). There are also individuals who initiate and sustain recovery within a particular mutual aid group, individuals who simultaneously attend different mutual aid groups (attending WFS and A.A. meetings concurrently), individuals who initiate recovery in one group and then shift affiliation to another group (e.g., movement from N.A. to A.A.), and individuals who initiate recovery in a group like A.A., then disengage from active participation in A.A., but successfully sustain long-term recovery (See White and Kurtz, 2005). There are individuals with severe AOD problems who experience natural recovery—the initiation and maintenance of recovery without professional treatment or involvement in a recovery mutual aid group (Tuchfeld, 1981; Biernacki, 1986, Granfield & Cloud, 1999).

So what do we make of all this? Given this diversity in styles of recovery initiation and maintenance, the best strategy is for each treatment program and addictions professional to develop a broad menu of recovery-focused ideas, activities, and mutual aid structures that can be offered to clients. Our job is not to coerce or convince clients that one particular framework of recovery is the best. Rather, it is to offer each client exposure to the successful pathways of recovery that others have used and to help each client find a framework and style of recovery that achieves a personal fit.

So what are the facts about recovery mutual aid groups in America? The following historically and scientifically grounded propositions constitute a good starting point.

1. Americans with severe alcohol and other drug problems have banded together for mutual support in recovery for more than 250 years (White, 1998, 2001b).
2. A.A., due to its large membership, wide geographical dispersion, wide adaptation to other problems, and organizational longevity has established itself as the standard by which other recovery mutual aid groups are evaluated (Room, 1989; Kurtz & White, 2003).
3. Participation in recovery mutual aid groups following addiction treatment enhances long-term recovery outcomes (Emrick, Tonigan, Montgomery & Little, 1993; Fiorentine, 1999; Humphreys, et al, 2004).
4. In spite of allegations to the contrary, recent studies confirm A.A. affiliation and recovery rates for women, people of color, young people, and people with co-occurring psychiatric disorders (including those on medication) are comparable to those reported for general A.A. membership (Humphreys, Mavis, & Stoffelmayr, 1994; See White & Kurtz, 2005, for a review).
5. There are alternatives to A.A. and Twelve Step programs that offer different goals (e.g., moderation-based groups), philosophies (e.g., explicitly religious and secular groups), and recovery initiation and maintenance strategies (Humphreys, 2004; White & Kurtz, 2005).

6. Most of what we know from the standpoint of science about recovery support groups is based on studies of A.A., although studies of other recovery support groups have increased in the past 25 years (Humphreys, 2004).
7. Studies of recovery mutual aid groups reveal evidence of a dose effect (recovery stability increases with number of meetings attended) (Humphreys, Moos & Cohen, 1997; Chappel, 1993) and an intensity effect (recovery stability increases with broader pattern of participation (e.g., applying concepts to daily problem solving, reading recovery literature, sober socializing, service work) (Montgomery, Miller & Tonigan, 1995; Humphreys, Moos & Cohen, 1997).
8. Completion of addiction treatment AND participation with recovery mutual aid groups is more predictive of long-term recovery than either alone (Fiorentine & Hillhouse, 2000).
9. All recovery mutual aid groups experience individuals who fully respond, individuals who partially respond, and individuals who do not respond at all to their program (Morgenstern, Kahler, Frey, & Labouvie, 1996).
10. Individuals may initiate recovery through one framework and then shift to another framework to maintain that recovery (e.g., African-American women shifting from A.A./N.A. for recovery initiation to use of the church as their primary source of support for recovery maintenance) (White, Woll, & Webber, 2003).

To embrace these propositions, treatment agencies and treatment professionals will need to broaden their tenets to embrace a philosophy of choice, strengthen their relationships with diverse communities of recovery and enhance and individualize their strategies for linking clients to particular communities of recovery (Woll, personal communication, 2006).

Unanswered Questions: Many questions about recovery mutual aid groups remain unanswered. Additional research is needed to enhance our ability to effectively match particular individuals to particular recovery support groups. A short sampling of critical unanswered (even unasked) questions include the following:

1. Are the findings from studies of A.A. applicable to other Twelve Step groups (e.g., N.A./C.A.) and to alternative recovery support structures?
2. What are the patterns of long-term affiliation (or disaffiliation) with A.A., and how are these patterns similar or different for other recovery support groups?
3. Does exposure to a moderation-based support group shorten addiction careers for some individuals by accelerating their commitment to sobriety following failed efforts to maintain moderation guidelines?
4. Which clinical practices in addiction treatment lead to the highest rates of affiliation with recovery support groups following treatment?
5. What are the recovery support needs of people in long-term addiction recovery and how do those needs differ from those in early recovery?
6. What factors contribute to relapse after 5-20+ years of continuous recovery?
7. Does participation in the recovery community outside of mutual support meetings play a role in the stability and quality of long-term recovery?

Mutual Aid Critics: Criticism of recovery mutual aid groups has generally focused on A.A. There is almost a cottage industry of A.A. and Twelve Step critics who contend that 1) A.A. is not successful or is successful with only certain types of alcoholics, 2) A.A.'s religious language keeps many alcoholics from seeking recovery, 3) People become too dependent on A.A. (charges that A.A. is a cult that creates "Twelve Step Zombies"), 4) A.A.'s reliance on a Higher Power undermines personal responsibility and development of internal strengths, 5) A.A. ignores environmental factors that contribute to alcohol problems, and 6) A.A.'s political influence has retarded the scientific advancement of the alcoholism treatment field and contributed to clinical rigidity (reviewed in White, 1998).

Perhaps more troublesome is the allegation in print (e.g., Gilliam, 1999; Fransway, 2000) and on the Internet (e.g., www.aadeprogramming.com or http://health.groups.yahoo.com/group/12-step-free/) that individuals have been harmed by affiliation with A.A. and related recovery support groups. These critiques raise important and currently unanswered (from the standpoint of science) questions such as: are all or particular mutual aid groups contraindicated for certain individuals who could be injured by their experiences within a mutual aid group? If so, what are the recognizable characteristics of such groups, the characteristics of the individuals most vulnerable to injury, and the nature of the injuries they could experience? Until such questions can be fully answered, we recommend promoting a choice philosophy and monitoring each client's ongoing responses to recovery support group participation.

The Choice Philosophy: A choice philosophy is based on the recognition of multiple pathways and styles of long-term recovery and the recognition of the right of each person to select a pathway and style of recovery that represents the individual's personal and aspirational values. Steps that addiction treatment programs can take to actualize a philosophy of choice are outlined below.

ACTUALIZING THE CHOICE PHILOSOPHY

- Professional counselors, recovery coaches and volunteers represent the diversity of pathways and styles of recovery.
- Professional counselors and recovery coaches are knowledgeable about the full spectrum of religious, spiritual and secular recovery support groups and can fluently express the catalytic ideas used within each of these frameworks.
- Professional counselors and recovery coaches are aware of patterns of co-attendance (concurrent or sequential participation in two or more recovery support structures, e.g., co-attendance at WFS and A.A. meetings, N.A. participation with later transitioning to A.A. as one's primary recovery support structure).

- Individuals and their families are educated about the variety of recovery experiences and the legitimacy of multiple pathways and styles of recovery.
- Informational materials, lectures and structured exercises that people receive represent the scope of recovery support options, e.g., posting all local recovery support meeting schedules on the treatment agency website and facility bulletin boards, giving each client a wallet card with the central contact numbers of local recovery support groups, profiling local recovery support groups in agency/alumni newsletters.
- Individual choice is respected; individuals receiving services are not demeaned or disrespected for the recovery support strategies they choose; clinical strategies involve motivational interviewing principles and techniques rather than coercion and confrontation.
- Professional counselors and recovery coaches are encouraged to self-identify and bring to supervision negative feelings they may have about a particular pathway of recovery chosen by a client.

Choice and the Stages of Recovery: To implement a choice philosophy, addictions counselors and recovery coaches must reconcile the philosophical and therapeutic value of choice with the growing evidence of how neurological impairments can impair the choice-making abilities of individuals in active addiction and early recovery (Dackis & O'Brien, 2005). The challenge for the addictions counselor or recovery coach is distinguishing authentic choice from what A.A. calls "stinkin' thinkin,'" what Rational Recovery calls the addictive voice or "Beast," what Secular Organization for Sobriety refers to as the "lizard brain," what LifeRing Secular Recovery calls the "addict self" (versus the "sober self"), and what Christian recovery groups refer to as the "voice of the Devil." Given the dichotomy between the sober self and the addicted self, the question becomes "Who's really choosing: Dr. Jekyll or Mr. Hyde?" Some would frame this as separating what each client wants/needs from what his or her disease wants/needs.

One way to partially reconcile this dilemma is to view recovery as a progressive rehabilitation of the will—the power to reclaim personal choice (Smith, 2005). At a practical level, this means that the first day of detox may not be the best time to rely exclusively on client choice. Without rehabilitation of the power to choose and an encouragement of choice, we get, not sustainable recovery, but superficial treatment compliance. To effectively apply a philosophy of choice will require discretion and skill where immaturity, acute psychiatric symptoms, drug impairment and impaired ability to read social cues severely limit choice generation, choice analysis and capacity to stick with any personal resolution. In such cases, we must carefully plot a path between complete autonomy (total choice and clinical abandonment) and paternalism (no choice). Scientific confirmation of this stance is found in a study in which people with severe alcohol problems, recognizing their impaired decision-making capacities, preferred therapist—set

goals in treatment; whereas those with less severe problems preferred self-set goals (Sobell, Sobell, Bogardis, Leo & Skinner, 1992).

Creating Informed Consumers: A philosophy of choice is viable only with persons who have the neurological capacity for decision-making, who believe they have the right to make their own choices and who are aware of and can evaluate available service and support options. Creating informed, assertive consumers of addiction treatment and recovery support services can be enhanced by: 1) affirming the service consumer's right to choose, 2) distributing and reviewing consumer guides on treatment and recovery support services published by recovery advocacy organizations, 3) teaching service consumers how to recognize quality services, 4) encouraging consumers to visit service options before making a decision (versus taking whatever is offered them), and 5) defining the criteria by which the client and service specialist will know if participation in a particular group is working or not working (Bev Haberle, personal communication). Similar considerations need to be extended to educate the family members of those needing or seeking recovery.

Choice and Limited Resource Alternatives: Another obstacle to implementing a choice philosophy is the limited recovery support options available today within many communities. Altering that situation requires moving from a clinical perspective to a recovery community development perspective. Recovery options are expanding, clients are using these options (either alone or in patterns of co-involvement with one or more support groups), and progressive treatment organizations are playing a role in nurturing the development of expanding recovery support resources. We will describe shortly how this can be achieved.

Building Relationships Between Treatment Organizations and Local Communities of Recovery

An emphasis on changing social networks to be conducive to recovery could heighten clinical effectiveness and prevention efforts within communities.

— Constance Weisner, Helen Matzger & Lee Ann Kaskutas, 2005

More work is needed to strengthen the ability of addiction treatment... to link patients to self-help programs and support their on-going participation in them.

—James McKay, 2005

...interventions should focus on enhancing continuation in AA and on identifying other mutual aid groups that may provide similar benefits.

— Rudolf & Bernice Moos, 2005

Relationships between treatment organizations, recovery mutual support groups and recovery community organizations have changed dramatically over the past 40 years. As noted earlier, the pattern of collaboration that once existed between treatment agencies and local mutual aid groups dissipated in the professionalization of addiction counseling and the industrialization of addiction treatment. The evidence presented earlier in this paper suggests the need to re-link addiction treatment to indigenous communities of recovery.

Linkage Philosophy: There are three critical points in shaping a philosophy of linkage between treatment agencies/professionals and recovery mutual aid groups and recovery community organizations. The first is that professional treatment can be viewed as an adjunct to recovery mutual aid groups, rather than seeing such groups as an adjunct to treatment. Secondly, recovery mutual aid groups can serve as an alternative to professional treatment (Humphreys & Moos, 2001; White & Kurtz, 2005). Let us state again recent findings that participation in professional treatment and recovery support groups generates better long-term recovery outcomes than participating in either professional treatment or recovery support groups alone (Fiorentine & Hillhouse, 2000). These findings are based on clinical studies of individuals who present to treatment with severe AOD problems and limited recovery support networks. There are, however, situations where recovery mutual aid groups stand as an appropriate initial choice over admission to professionally directed addiction treatment. This occurs when individuals present with lower problem severity and high recovery capital (internal and external recovery support assets). In this case, an individual could be referred to a recovery

support group and their responses monitored to see if he or she can initiate and sustain recovery without the need for professional treatment. This alternative can potentially avoid the expense of treatment and the stigma and discrimination that can accompany diagnosis and treatment of a substance use disorder. Within this philosophical stance, addiction treatment is not the first line of response for AOD problems, but a safety net for those individuals who cannot resolve AOD problems through nonprofessional family and community supports.

A second point in this linkage philosophy is the need to respect the principles and guidelines recovery support groups have established to govern their relationships with outside organizations. Efforts must be made by the treatment agency to understand and abide by such principles as they differ from group to group. Twelve Step groups rely on codified traditions that govern their group life and their external relationships. A.A.'s Twelve Traditions, for example, would suggest that addiction treatment agencies not:

- refer individuals to closed A.A. meetings who do not meet A.A.'s requirement for membership as set forth in Tradition Three ("The only requirement for A.A. membership is a desire to stop drinking.")
- involve A.A. service committees in matters unrelated to carrying a message of hope to alcoholics (Tradition Five: "Each group has but one primary purpose—to carry the message to the alcoholic who still suffers.")
- use the A.A. name in any promotional material that would inadvertently convey A.A.'s endorsement of the treatment agency or that A.A. was affiliated with or a part of the treatment agency (Tradition Six: "An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.")
- offer financial contributions to A.A. (Tradition Seven: "Every A.A. group ought to be fully self-supporting, declining outside contributions.")
- entitle roles (e.g., "A.A. Counselor") with names that convey the professionalization of the A.A.'s service to still-suffering alcoholics (Tradition Eight: "Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.")
- solicit A.A.'s opinion on any outside issue or otherwise draw A.A. into any public controversy (Tradition Ten: "Alcoholics Anonymous has no opinion on outside issues, hence the name of A.A. ought never be drawn into public controversy.")
- violate the anonymity of any A.A. member by linking their full name and A.A. affiliation at the level of press, radio or film (Tradition Eleven: "Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.") (Alcoholics Anonymous, 19821).

A third point is that groups claiming to be recovery support groups ought to also be held accountable by treatment facilities to certain basic standards, including

the expectation that such groups be based on testable principles of personal change, are accountable for recovery outcomes, do not interfere with the medical treatment of their members, do not financially, sexually or emotionally exploit their members, and do not claim expertise for which they possess no education, training and experience (Nicolaus, personal communication, 2006). Recovery mutual aid group experiences are not universally positive and some such experiences may be harmful. Professionals have a responsibility to understand the potential for such harm and injury, orient their clients to the potential risks as well as benefits of support group participation, link their clients to particular individuals and groups that have a reputation for integrity, and monitor each client's experiences within those groups that have been recommended. When a client is not experiencing positive benefits from participation in a particular group or risks injury from such continued participation, then disengagement from that group and the exploration of alternative sources of recovery support are indicated and should be encouraged. Problems of attrition in recovery mutual aid groups are usually conceptualized as a failure of the individual, but such attrition should also be a source of feedback about and to the recovery mutual aid group.

A final point in this linkage philosophy is a reaffirmation of the earlier philosophy of choice that calls for respect for different relational styles of recovery and respect for the legitimacy of different recovery pathways (religious, spiritual, secular) and their respective support groups (White & Nicolaus, 2005). By relational style, we refer to how individuals in recovery relate or do not relate to others in recovery. There are acultural styles in which individuals recover without relationships with others in recovery, bicultural styles in which individuals have a balanced social network of people in recovery and "civilians" (those without addiction/recovery experience), and culturally enmeshed styles in which individuals are almost completely absorbed in relationships with other people in recovery (White & Kurtz, 2005). We recommend a linkage philosophy that includes tolerance for acultural styles of recovery (particularly for those with low problem severity and high recovery capital) as well as tolerance for very enmeshed styles of recovery. Persons with deep, prolonged involvement in cultures of addiction may require an enmeshed style of early recovery. There is recent evidence that these affiliation styles change for many people over the course of recovery (Kaskutas, et al, 2005).

Goals of Linkage Process: There are three primary goals for linking individuals in addiction treatment to recovery support groups and the larger communities of recovery: 1) to solidify recovery initiation (problem identification, recovery commitment, resolution of personal/environmental obstacles to recovery, beginning identity and lifestyle reconstruction), 2) to connect each individual/family to a community of recovered and recovering people with whom they can share their experience, strength and hope, and 3) to provide communal guidance for the transition from recovery initiation/stabilization to long-term recovery maintenance.

Linkage Principles: There are several scientifically and clinically grounded findings and principles that should guide the linkage of clients to recovery support groups.

- Assertive linkage (facilitating the connection between the client and a particular individual/group) is more effective than passive linkage (verbal encouragement) (Weiss, et al 2000).
- 40% of clients discharged from treatment do not participate in recovery support groups in the weeks and months following their discharge (Moos & Moos, 2005).
- Rapid entry into involvement with a recovery support group during treatment services generates better long-term recovery outcomes than delayed linkage (e.g., following treatment or at a period subsequent to treatment) (Moos & Moos, 2005).
- Broader patterns of recovery support group participation are more predictive of sustained remission than the more restrictive measure of meeting attendance (Montgomery, Miller & Tonigan, 1995; Humphreys, Moos & Cohen, 1997).
- The longer the participation in recovery support groups in the three years following primary treatment, the greater the probability of remission at 15+ years following treatment (Moos & Moos, 2005).
- There are high early dropout rates in recovery support group participation (in the 40-70% range) (Kelly & Moos, 2003; Moos & Moos, 2005).
- Sustaining and increasing recovery support group involvement over years 1-3 following treatment is associated with stable remission at subsequent follow-up (Moos & Moos, 2005).
- While some individuals disengage from recovery support groups after a period of recovery initiation and sustain stable remission (Kaskutas, et al, 2005), those who sustain recovery support group participation are more likely to be in remission at follow-up than those who disengage (Moos & Moos, 2005).

These findings suggest an assertive linkage process that begins immediately upon treatment initiation, is monitored over time and includes ongoing coaching for recovery support group participation and, when indicated, re-linkage to past or alternative groups following disengagement.

Measurable Benchmarks: The effectiveness of this linkage process can be reflected in two types of benchmarks. The first involves individual or collective process measures such as percentage of clients involved in recovery support meetings during the first 30 days following their discharge from treatment, the total and average number of weekly meetings attended in the first 90 days following discharge from treatment or the percentage of individuals referred to Twelve Step groups who have a temporary or permanent sponsor within 30 days of discharge. The second type of measurable benchmark involves collective changes in clinical/recovery outcomes that follow development of assertive linkage processes. Such hoped for outcome measures would include decreases in post-treatment relapse rates, extended lengths of time from discharge to first use, shorter episodes of lapse/relapse, reductions in treatment readmissions, lower post-treatment mortality rates and increases in quality of recovery measures.

Working with Mutual Aid Service Structures: Most recovery mutual aid groups have established service structures and procedures that guide the relationship between each group and treatment organization. The most formal of these guidelines are the Hospital and Institutions (H&I) Committees (also referred to as Treatment Facility [T.F.] Committees) developed within A.A. and replicated with minor adaptations in N.A., C.A. and other Twelve Step groups. A good orientation to H&I Committees and the relationship between Twelve Step programs and treatment organizations can be obtained by reviewing the following documents:

- *A.A. Guidelines: Treatment Facility Committees*

  http://www.alcoholics-anonymous.org/default/en_pdfs/mg-14_treatfacilcomm.pdf.
- *How A.A. Members Cooperate with other Community Efforts to Help Alcoholics* (A.A. Pamphlet)
- *A.A. and Treatment Facilities* (A.A. Pamphlet)
- *A.A. in Hospitals* (A.A. Pamphlet)
- *Basic H & I Guide of Narcotics Anonymous* http://www.na.org/h-i/hi-guidetoc05.htm
- *Narcotics Anonymous: In Cooperation with Therapeutic Communities Worldwide* (http://www.na.org/prespapers/in-cooperation.htm)

Some readers may respond that they have attempted to work with such committees but found them populated with "fundamentalists" who were not open to new ways of engaging and retaining individuals who have struggled to achieve stable recovery. Relationships with service committees are best approached as a long-term endeavor requiring tolerance, mutual respect and a process of mutual learning.

The service structure of recovery programs not based on the Twelve Steps can be found on the Internet websites of these organizations or by contacting them directly. Links to these sites and organizations can be found at http://facesandvoicesofrecovery.org/resources/support_home.php.

We would offer the following suggestions to build or renew the relationship between local treatment organizations and local recovery support groups:

- Respect the guidelines that each group has established for members who work or serve as volunteers in the addictions field (See *A.A. Guidelines for A.A. Members Employed in the Alcoholism Field.* (ND). New York: General Service Office, Alcoholics Anonymous.)
- Where possible, develop a single point of contact with each group (e.g., the chairperson of the H&I Committee).
- Establish at least annual meetings between your agency and the service committees of local recovery support groups to review such issues as support meetings hosted at the treatment facility, transportation assistance to outside meetings, access to literature for clients, procedures for temporary

sponsorship, use of speakers to make presentations about the group to clients, and any problems that have arisen in the relationship between the treatment facility, its clients, and the group.

- To help personalize the linkage process (in consultation with the service committee or representative), develop a cadre of reliable individuals with diverse characteristics and temperaments that will serve as temporary guides in getting a new person welcomed into the group.
- Avoid linkage practices that potentially violate the culture of the local group (e.g., busing 30 new people in treatment to a small community meeting or linking heroin addicts without a history of alcohol use/problems to A.A. with narrow interpretations of A.A.'s tradition governing membership.)

In a process aimed at reconnecting treatment, recovery and community, treatment leaders are again beginning to define themselves as a part of the growing recovery community and see themselves as personally and institutionally accountable to this recovery community. Leaders and staff of progressive treatment organizations are again participating in communal meetings of local communities of recovery and opening the doors of their facilities to local recovery communities as a venue for social support and service. Leaders within American communities of recovery are also beginning to articulate the need for these communities to more effectively reach out to treatment organizations and the individuals and families they serve.

Encouraging Staff Exposure and Participation in Local Recovery Support Groups and Internet-based Recovery Resources: Assertive linkage to recovery support groups and the larger network of recovery community resources requires an in-depth knowledge of these local groups and resources. In the 1960s and 1970s, participation in local (open) meetings was expected of all staff, a practice that created an in-depth knowledge of different recovery support structures and something of the personality of each particular meeting. The shift from acute models of care to recovery management will stir calls for a renewal of this knowledge base. Programs can enhance this knowledge by encouraging service staff and volunteers to:

- read the literature of the spectrum of recovery support groups,
- visit open meetings of local recovery support groups,
- visit Internet sites of the major recovery support groups and become familiar with various on-line recovery support meetings,
- invite representatives of various recovery support groups to provide in-service training for clinical and support staff, and
- participate in local recovery celebration activities either as a person in recovery or a friend of recovery.

Developing Recovery Volunteer Programs: One of the most vibrant recovery volunteer programs developed by an addiction treatment program was that developed at Lutheran General Hospital in the early 1970s. The hospital's alcoholism treatment unit recruited more than 200 volunteer A.A. and Al-Anon members who

collectively provided more than 10,000 hours of volunteer service each year. The volunteers provided around-the-clock social support to the individuals and families going through treatment and helped link them to outside support meetings in the community (McInerney, 1970). Such dynamic volunteer programs dissipated amid the growing professionalization of the field in the 1980s and 1990s, but efforts to restore them are increasing as part of the larger shift from acute models of treatment to models of sustained recovery management. Portrayed below are some of the functions that recovery volunteers can provide within the treatment milieu.[4]

REPRESENTATIVE FUNCTIONS OF RECOVERY COMMUNITY VOLUNTEERS

1. Offering themselves as "living proof" of the reality of recovery and the transformative power of recovery.
2. Sharing their recovery status and, when well timed and appropriate, their recovery story.
3. Serving as a recovery lifestyle consultant, sharing practical tips on living as a person in recovery within one's family, school or workplace and larger community.
4. Helping staff and paid peer-support specialists guide the client/family into relationships with one or more local or virtual communities of recovery.
5. Providing support (e.g., information, transportation) and advocacy to each client/family to facilitate access to needed recovery services.
6. Providing face-to-face, telephone and e-mail communications for purposes of monitoring, recovery coaching, and, when needed, early re-intervention.
7. Training family members (or persons in recovery) to run family education seminars and family support groups.

Developing or Renewing Recovery (Alumni) Associations: One of the dynamic bridges between treatment and the larger recovery community is provided through recovery (alumni) associations that provide recovery support services in their own right to clients during and following treatment and who constitute an important pool from which volunteers can be drawn.

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4 Those interested in developing or enhancing a recovery volunteer program will find the following resource helpful: Successful Strategies for Recruiting, Training, and Utilizing Volunteers: A Guide for Faith- and Community-based Service Providers*. (2005). Rockville, MD: USDHHS, SAMHSA, CSAT. To order, call 1-800-729-6686.*

PROFILE OF A VIBRANT AND ENDURING RECOVERY ALUMNI ASSOCIATION

Group:	Discovery (Alumni Association of New Day Center at Hinsdale Hospital, Hinsdale, IL)
Founded:	Early 1980s
Founded by:	John Daniels (aftercare director) and two graduates and their spouses.
Membership Size:	Ranged between 250-500 over past ten years
Duration of Participation:	30-40% have participated for more than 5 years with some of the founding members still participating
Meeting Frequency:	Monthly social events and 2-3 organizational meetings each year
Social Event Activities:	Potlucks, dinners out, bowling, weekend trips
Average Event Attendance:	60-70
Distinctiveness / Keys to Success:	Involvement of partners/spouses and children; development of long-term relationships with individuals/families in recovery; autonomy of group from treatment organization (New Day only provides space and assistance with mailings)
Membership Fee:	$5 per person per year
Association Assets:	Approximately $10,000 used to support activities and participation of any members who cannot afford activities.
Greatest Challenge to Date:	Engaging and retaining adolescents after treatment.

Source: Interview with Don Malec, Discovery Leader, January 19, 2006.

Recovery alumni associations can exist as a permanent recovery support structure or as a transitory support structure with its need diminishing as those completing primary treatment become more involved within and interact within local communities of recovery (Schwartz, personal communication, 2006). It is our experience that programs that most effectively link individuals to natural communities of recovery diminish the need for the treatment center alumni association as a support structure.

Developing Formal Peer-based Recovery Support Programs: There are a growing number of treatment and recovery support organizations experimenting with Peer-based recovery support services (P-BRSS) via new service roles (recovery coaches, peer assistants, recovery mentors, recovery support specialists). P-BRSS are non-clinical services offered on a paid or volunteer basis that guide individuals and families into a recovery-based lifestyle following severe alcohol and other drug problems. P-BRSS offer normative guidance on the recovery experience (stage-appropriate recovery education), linkage to communities of recovery, consultation on problems encountered in early recovery, ongoing monitoring of recovery stability, assistance with lifestyle reconstruction (e.g., sober

housing, sober leisure, etc.), and, when needed, a point of early re-intervention into lapses or relapses. P-BRSS are reflected in new roles going by such titles as recovery coaches, peer recovery mentors, recovery support specialists and recovery assistants. Peer-based recovery support services are being implemented under a variety of rationales (White, 2004).

1. Helpers derive significant therapeutic benefit from the process of assisting others (the "helper principle") (Riessman, 1965, 1990).
2. People who have overcome adversity can develop special sensitivities and skills in helping others experiencing the same adversity — a "wounded healer" tradition that has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements.
3. The inadequacy of acute care models of treatment for people with high problem severity and complexity and low recovery capital is evident in low engagement rates, high attrition rates during treatment, low continuing care participation, and high re-admission rates.
4. Many addicted people benefit from a personal "guide" who facilitates disengagement from the culture of addiction and engagement in a culture of recovery.
5. Peer-based recovery support relationships that are natural, reciprocal and enduring are not mutually exclusive of, but qualitatively superior to, relationships that are hierarchical, commercialized and transient.
6. P-BRSS are an attempt to re-link treatment and recovery, move the locus of treatment from the treatment institution into the natural environment of those seeking treatment services, and facilitate the shift from toxic drug dependencies to "prodependence on peers" (Nealon-Woods, et al, 1995).

P-BRSS are being piloted in some of the White House-initiated Access to Recovery Programs, within the Center for Substance Abuse Treatment's Recovery Community Services Program (RCSP), and within a growing number of programs experimenting with models of recovery management. The states of Connecticut, Arizona and Vermont have taken the lead in encouraging the development of recovery coach roles in treatment and recovery advocacy and support organizations, and there is a recent trend toward the privatization of recovery support services (e.g., Hired Power www.hiredpower.com).

Seen as a whole, the recovery coach role is comprised of multiple roles. The recovery coach is a:

- motivator and cheerleader (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement),
- ally and confidant (genuinely cares, listens and can be trusted with confidences)
- truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting),
- role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice),

- problem solver (identifies and helps resolve personal and environmental obstacles to recovery),
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support),
- advocate (helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights),
- community organizer (helps develop and expand available recovery support resources and affect policies that will support long-term recovery),
- lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living), and
- a friend (provides companionship) (White, 2004).

It is also important to note what the recovery coach role is not. First, the recovery coach is not a therapist or counselor, although certain qualities and functions overlap with this role. This fact is reflected in the retraining that must occur when persons in recovery who are certified addiction counselors, psychologists and social workers volunteer to serve as addiction counselors. Such individuals must be retrained to eschew professional jargon and counseling techniques for a true peer support role (Ben Bass, personal communication, date?). The recovery coach also is not a Twelve Step sponsor and must not duplicate support activities that are being or could be provided by the larger recovery community. (White, 2006)[5]

There are many models of organizing P-BRSS. One model gaining increasing attention is that of the Recovery Community Center (RCC) developed by the Connecticut Community of Addiction Recovery (CCAR), which describes its RCC as follows:

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

At CCAR, the RCC moves recovery from "the church basements to main street," provides a venue for sober socializing, a physical place for recovery development (linkage to recovery-conducive employment, recovery homes, recovery workshops, planned leisure activities, community service work) and as a medium for connecting people with recovery needs to people with recovery assets. CCAR sees its RCC as an organizational/human bridge between the professional treatment community and the recovery community. Where addiction counselors and Twelve-Step sponsors view their service focus in terms of individuals/families that have sought their help, the RCC defines its "client" as the community—the WHOLE community. It is an innovative framework through which peer-based recovery support services can be delivered.

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5 See Loveland and Boyle (2005) for a recovery coach implementation manual.

2006 PROFILE OF THE VERMONT RECOVERY CENTER NETWORK

Number of Recovery Centers (RC):	6
Usual Hours of Operation:	8 am to 10 pm
Average hours per week of Operation:	69
Number of Full- and Part-time Paid staff:	9
Primary Financial Support:	Yearly grant from Vermont Department of Health / Division of Alcohol and Drug Abuse Programs
Secondary Financial Support:	Local grants, local fundraising, membership fees
Number of Volunteers Per Center:	Ranges from 7-50; average of 27 per center
Average Weekly Volunteer Hours per Center:	Ranges from 20-225; averages 93 volunteer hours per week/per center
Number of Weekly Recovery Meetings:	Range from 4-20; total of 66 recovery meetings per week at the 6 centers
Total Number of Participant Visits Past Quarter:	20,741
Average Age of Participants:	41
Average Length To Date of RC Participation:	1.75 years
% of Participant Evaluations Noting Role of RC in Finding Recovery:	55%
% of Participant Evaluations Noting Role of RC in Maintaining Recovery:	94%
% of Participants Who Have Participated in Treatment Programs in their Lifetime:	73%
% of Participants Who Have Participated in Treatment Programs in Past Year:	24%
Core RC Activities:	Social support and fellowship, recovery meetings, recovery education (e.g., life skills training), linkage to specific services (e.g., treatment, housing, family services, employment, etc.), and social activities.
Future Vision:	12 recovery centers geographically dispersed across the state, enhanced linkage between professional treatment and local recovery support centers, and increased community awareness of recovery by making recovery visible on “main street.”

Source: Personal Communication, Patty McCarthy, Executive Director, Friends of Recovery Vermont; Data from Vermont Department of Health / Division of Alcohol and Drug Abuse Programs

Peer-based recovery support services are not without potential pitfalls, including: the vulnerability of peer service providers and recipients; problems of role delineation among coach, counselor and sponsor; the lack of models for recruitment, orientation/training, and ongoing supervision of P-BRSS specialists; and the lack of a code of ethics to guide the delivery of peer-based services (e.g., guidelines on such issues as self-disclosure, boundaries of competence, dual relationships, gifts, and level of accessibility, to name just a few).

The Process of Linking Clients/Families to Recovery Support Groups and Communities of Recovery

Traditional "Aftercare" versus Assertive Approaches to Continuing Care (AACC): Revamping the process of linking clients to communities of recovery is part of the larger revamping of the traditional idea of "aftercare." In the traditional view, acute treatment initiates and stabilizes recovery and provides aftercare in the form of step-down treatment (outpatient sessions following discharge from residential). Participation in professionally directed "aftercare groups" and participation in A.A. or other recovery support groups would serve to maintain recovery. In this model, aftercare arrangements rely primarily upon verbal encouragement for such participation to each client by his or her counselor and are only available to those clients who have completed recommended levels of care.

In the new recovery management model, all care is part of a process of assertive continuing care. In contrast to traditional aftercare models, assertive approaches to continuing care:

- encompass all admitted clients/families, not just those who successfully "graduate," including those who terminated treatment against staff advice or were administratively ("therapeutically") discharged,
- place primary responsibility for post-treatment contact in AACC with the treatment institution, not the client,
- involve both scheduled and unscheduled contact (e.g., "I've been thinking about you today and thought I would call to say hi and see how things were going."),
- capitalize on temporal windows of vulnerability (saturation of check-ups and support in the first 90 days following treatment) and increase monitoring and support during periods of identified vulnerability,
- individualize (increases and decreases) the duration and intensity of check-ups and support based on each client's degree of problem severity, the depth of his or her recovery capital and the ongoing stability or instability of his or her recovery program,
- utilize assertive (see discussion below) linkage rather than passive referral to communities of recovery,[6]
- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support and mailed and e-mailed communications,
- place emphasis on those combinations and sequences of services/experiences that can facilitate the movement from recovery initiation to stable recovery maintenance,

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6 Referral is not linkage; it is affirmation of the need for linkage and the hope that linkage will happen. Linkage is a process that assures that the connection between an individual and indigenous recovery support systems really happens.

- emphasize support contacts with clients in their natural environments,
- may be delivered either by counselors, recovery coaches or trained volunteer recovery support specialists, and
- emphasize continuity of contact and service (rapport building and rapport maintenance) in a primary recovery support relationship over time (Dr. Mark Godley, Director of Research, Chestnut Health Systems, personal communication, February, 2006).

Building a Long-term Recovery Support Relationship: Clients receive mixed messages from those of us in the addiction treatment field. We TELL them that addiction is a chronic disorder and then treat them in ever-briefer episodes of treatment. We TELL them that recovery is a prolonged process rather than an event, but then we "discharge"/"graduate" and abandon them to pursue this process on their own. We TALK about the importance of post-treatment recovery support through peer-based recovery support groups, but we do not monitor the strength and durability of such connections. We TELL clients if they get in trouble after treatment to get back to us for additional help, but we all too often shame the returning client to the point that many stop seeking treatment or keep seeking help at new treatment centers. If we as addiction professionals really believe that addiction is a chronic disorder, then it is time our professional behavior matched our professional rhetoric.

Linking clients to recovery support groups and broader communities of recovery is best achieved within a long-term recovery support relationship, whether the person who initiates that relationship is a counselor or a paid or volunteer recovery coach. As noted earlier, addiction researchers are investigating the power of post-treatment check-ups and support via face-to-face-interviews, mail and telephone contact and Internet-based monitoring and support. New research technologies, generating 90+% follow-up rates in longitudinal studies of addiction treatment, could be clinically adapted for use as ongoing recovery support interventions (Scott & Dennis, 2000). Such technologies create positive space in peoples' lives to forge long-term relationships that have meaning and value. Treatment centers such as the Betty Ford Center and Hazelden are trying to extend their support services beyond primary treatment through the use of telephone-based check-ups over the months following treatment.

Competing with the Culture of Addiction: Many clients with severe AOD problems are deeply enmeshed in cultures of addiction—an entrenched pattern of daily rituals and social relationships that sustain addiction. The fragileness of post-treatment adjustment is in part due to the resurging siren call of these rituals and relationships. To put it bluntly, representatives from the culture of addiction conduct aggressive post-treatment monitoring and re-intervention with individuals who have completed treatment, but we do not. What is wrong with this picture? If we are truly committed to helping our clients achieve long-term recovery and recognize that they are precariously balanced between recovery and re-addiction in the days, weeks, months and early years following treatment, then we must be in their lives as a positive influence on these daily

recovery or re-addiction decisions that are made and help replace this culture of addiction with a culture of recovery (White, 1996).

Linkage Steps: Encouragement procedures can increase recovery support group affiliation and participation. Such procedures include:

- educating clients about the importance and potential benefits of post-treatment recovery support services ("Just as clients often minimize the severity of their AOD problems, they also tend to underestimate what will be required to successfully resolve those problems."),
- soliciting the client's past experience with solo experiments in sobriety,
- soliciting client's past experience with and perceptions (stereotypes) of recovery mutual aid groups,
- reviewing the menu of post-treatment recovery support options (family, social, occupational, formal support groups),
- identifying important meeting characteristics (e.g., religious, spiritual, secular; smoking or nonsmoking; gender; ethnicity; age; geographical access) (Forman, 2002),
- using assertive rather than passive linkage procedures, e.g., orienting the client about what to expect in his or her first meeting (As an example, see http://www.aa.org/default/en_about_aa.cfm?pageid=25, http://www.bma-wellness.com/papers/First_AA_Meeting.html and http://www.bma-wellness.com/papers/First_AA_Meeting.html#Locating%20a%20meeting)as a guide for what the client can expect at his or her first A.A. meeting),
- linking each client to a particular person (from a list of volunteer guides) to orient and guide the client into relationship with a local group and linking each client to a specific meeting for their initial exposure,
- demonstrating personal enthusiasm and optimism to the client about recovery support group participation,
- resolving obstacles to participation, e.g., day care, transportation,
- clarifying the role differences between the counselor, the recovery coach and the sponsor to avoid confusion, conflicting loyalties and manipulative splitting by the client,
- monitoring and evaluating each client's initial and ongoing responses to that person/meeting via follow-up phone calls, e-mails, or visits,
- providing support for continued contact or exploring alternatives in response to mismatches between person and group, and
- linking (where possible) family members to support structures congruent with the recovery framework of the client, e.g., referring spouses and children to Al-Anon and Alateen when the client is participating in A.A.[7]

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7 *For evidence of the effectiveness of encouragement procedures, see Mallams, et al, 1982.*

In most cases, the addiction counselor will have explored the potential value of recovery support group participation by the end of primary treatment. When this is not the case, then the counselor or recovery coach responsible for post-treatment check-ups must begin this process anew. Reinforcing the importance of recovery support group participation can begin with helping the client re-assess his or her past efforts at solo problem resolution.

PAST PROBLEM RESOLUTION EFFORTS
(KEY INTERVIEW QUESTIONS)

1. How many times have you attempted on your own to cut down your alcohol or other drug use?
2. What is the longest time you were able to sustain your goal of cutting down?
3. How many times have you attempted on your own to stop your alcohol and other drug use?
4. What is the longest time you were able to sustain your goal of not drinking or using drugs?
5. Is there an average time that your efforts to cut down or stop use started to fail for you?
6. In your best past prior efforts to cut down or stop your drinking and/or drug use, what were you doing that helped make this effort more successful?
7. Which do you think is most achievable for you in the future: cutting down your alcohol and/or drug use or stopping all non-medical use of alcohol and drugs?
8. If you use your past experience as a guide, what can you do in the next year to make your current efforts more successful?
9. How will you know if what you are trying now is working for you?
10. What are the earliest signs that would tell you that the strategy you are using this time is not working?

Some clients will sustain their recovery without recovery support group participation, while others will come to see such participation as helpful or essential. The goal is not to get all clients to *like* going to recovery support meetings, although some will develop that sentiment. The goal is to draw from the client's own experience why he or she *needs* to participate in such groups and to use their experience to determine what type of group best meets that need. There is something almost mystical in the chemistry between the individual and a recovery support group/community.

> When we speak of "recovery community," these qualities take on added significance because of the shared wounds its members bring to their membership in this community. It is here that those who have never experienced sanctuary often discover a place where they feel physically and psychologically safe for the first time. Here one is accepted not in spite of one's imperfectness but because of the very nature of that imperfectness. It is this shared "torn-to-pieces-hood" (as William James called it) that turns "people who normally would not mix" into a "fellowship." It is here that, in discovering one's self in the stories of others, people discover themselves and a "narrative community" whose members not only exchange their stories but possess a "shared story." Within such a community, one can find a deep sense of fit, a sense of finally discovering and connecting to the whole of which one is a part. The recovery community is a place where shared pain and hope can be woven by its members into life-saving stories whose mutual exchange is more akin to communion than communication. This sanctuary of the estranged fills spiritual as well as physical space. It is a place of refuge, refreshment and renewal. It is a place that defies commercialization—a place whose most important assets are not for sale. There is in this dynamic interaction [of person and group] as much a sense of having been chosen as there is a sense of choosing a particular framework of recovery. It is both a "you belong with us" connection between the group and the individual and a "this is where I belong" connection between the individual and the group. (White, 2001a)

That type of connection can be enhanced by reviewing each client's history of exposure to recovery support groups[8], his or her attitudes toward such groups, the factors most important to a positive group experience and his or her plans for immediate participation in such groups.

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8 For a more detailed format for reviewing past support group experience, see Nicolaus, M. (2003). Recovery by Choice*. Oakland, CA: LifeRing Press, pp. 235-241.*

WHICH OF THE FOLLOWING ARE IMPORTANT FOR YOU IN SELECTING A RECOVERY SUPPORT GROUP? PEOPLE WHO:
(CHECK ALL THAT APPLY)

- ❑ have experience with my primary drug
- ❑ are the same gender
- ❑ are close to my age
- ❑ share my ethnic/cultural background
- ❑ share my views on religion, spirituality or secularity
- ❑ share my sexual orientation
- ❑ smoke tobacco
- ❑ do not smoke tobacco
- ❑ have tolerant attitudes toward mental illness
- ❑ have tolerant attitudes toward medications prescribed for addiction or mental illness
- ❑ have prior experience in the criminal justice system
- ❑ do not have prior experience in the criminal justice system
- ❑ have approximately the same income level
- ❑ have had very severe alcohol/drug problems
- ❑ have had mild to moderate alcohol/drug problems
- ❑ share my goal of complete abstinence
- ❑ share my goal of moderated use

Once a plan has been formulated, the addiction counselor or recovery coach can begin the process of assertively linking the client to a recovery support group and its larger community of recovery. There are two phases in this linkage process. The first phase, opening the referral, begins in the planning process and proceeds through two additional steps: 1) when necessary, orienting the client to the particular recovery support society he or she has chosen to explore and 2) providing a direct, human connection between the client and either a representative of a recovery support organization or his or her first exposure to meetings of that society. The second step can be achieved by facilitating a visit between the client and a recovery group representative or the recovery coach taking the client to his or her first meeting. Where a guide is used, an important point is that the connection between the client and the recovery group is not complete until the guide steps out of the middle of that formative relationship.

The second phase is closing the referral linkage. Where the first stage guided the client into relationship with a community of recovered and recovering people, the second stage is designed to ensure individual-group fit by assessing strength and durability of relationship between the client and the group. Such assessment can be incorporated into routine post-treatment check-ups.

When Few Recovery Support Resources are Available: In communities with few recovery support resources it may be necessary for the addictions counselor or recovery coach to devote time to developing a broader pool of recovery support resources in the community. As an example, addictions counselors working in adolescent treatment programs often send adolescents back to local community and school environments with no indigenous recovery support services. The inevitable result is a high relapse rate—events that often occur within hours or days following discharge from treatment. An alternative approach is to supplement clinical services to the adolescent and family with time in the adolescent's community organizing school-based recovery support services and youth-oriented recovery groups and recovery activities.

In communities where few specialized recovery support resources exist and clients are not affiliated with mainstream recovery groups, special supports may be organized that can evolve into more permanent recovery support structures. This strategy can exert an important role in the growth, diversity and vitality of the local recovery community.

STEPS IN DEVELOPING SPECIAL RECOVERY SUPPOR GROUPS

- Identify an area of unmet need for recovery support, e.g., the absence of women's meetings, young people's meetings, absence of secular recovery groups, etc.
- Sponsor an open-attend (attend as long as you like) continuing care group as an adjunct or alternative (for some).
- Continue the group until a strong core group of members coalesces.
- Recruit the strongest group members as peer-leaders, encourage and cultivate their leadership, decrease your role but not your presence as their leadership activities increase.
- Arrange for your peer-leaders to facilitate the group sometimes in your absence and process with the leaders and group members how this went in your absence.
- Raise the possibility of shifting the group from a professionally directed continuing care group to a peer-sponsored and peer-led recovery support group.
- Provide information to assist group if they want to shift the group to a registered A.A., N.A. or other established recovery group.
- Monitor the status of the group and provide support to peer leaders.

NOTE: Ongoing cycles of this process may be required when established leaders relocate or mature out (in the case of young people's meetings).

Steps to Expand the Variety of Recovery Support Groups: Some communities lack Twelve Step recovery groups or alternatives to Twelve Step groups. Counselors and addiction counselors also can play important roles in enhancing the varieties of recovery support structures within their local communities.

SEEDING DIVERSITY IN LOCAL RECOVERY SUPPORT GROUPS

1. Remain personally knowledgeable and up to date on established and new recovery support groups.
2. Maintain a library of recovery support group literature and contact information that can be shared with your clients.
3. Encourage clients with computer resources and capabilities to explore the websites of various recovery support groups and to explore the world of Internet recovery support meetings. (Be prepared to provide cards with website listings.)
4. Invite guest speakers representing various recovery groups to visit your community and make presentations to clients and other interested parties.
5. Encourage individuals who are not responding to existing support structures to consider starting their own recovery support group.
6. Make clients aware of the growing movement to create broader recovery support structures, e.g., recovery homes, recovery schools, recovery work co-ops, etc.
7. Serve as a consultant to recovering individuals/families who want to explore development of a special recovery support group.

Providing Long-term Recovery Management

Linking clients from addiction treatment to communities of recovery has the greatest impact when this activity is imbedded within a large framework of long-term recovery management and support that encompasses pre-treatment engagement and recovery priming (motivational enhancement), in-treatment recovery support services (to enhance engagement, strengthen recovery initiation, and reduce treatment attrition) and post-treatment recovery support services. Our focus will be on the latter of these service categories.

Post-treatment recovery management begins at the point of discharge from primary treatment. In the emerging recovery management model, this period is considered the key to fully transferring what the client learned in treatment to his or her natural life in the community. The steps in this process include 1) ongoing check-ups and support, 2) stage appropriate recovery education (recovery coaching), 3) validating or reinitiating assertive linkage to recovery support groups and the larger network of community recovery activities, 4) resolving personal and environmental obstacles to recovery, and, 5) when needed, early re-intervention and re-linkage to recovery support group resources or professional treatment. The following discussion focuses primarily upon the check-up and linking functions.

Monitoring involves mutually agreed upon contact between the client and a recovery coach so that both may assess the client's status and explore the recovery process. The monitoring process usually begins with a higher frequency of contact in the first 90 days following treatment and decreases in frequency and intensity after that, with the proviso that check-up frequency can increase by mutual agreement at any time the client enters a period of heightened vulnerability. In most cases, clients with lower problem severity and higher recovery capital require shorter and lower intensity monitoring than do those with higher problem severity and lower recovery capital.

The major factor that compromises recovery from chronic health care problems is failure of the individual to adhere to recovery maintenance protocol, e.g., following medication directions, diet restrictions, exercise recommendations and other self-care prescriptions (McLellan, et al, 2000). Sustained monitoring is a powerful tool to enhance adherence to recovery maintenance protocol, a fact revealed in the addictions field from the discovery that research follow-up contacts actually generate their own therapeutic effects (Sobell and Sobell, 1981).

The following table illustrates the range of interventions that are indicated across five different circumstances the client may be in at the time of follow-up contact.

Source: Adapted and amplified from Stout, et al, 1999.

STATUS AT FOLLOW-UP	INTERVENTION OPTIONS
No Problems Reported	- Expressions of regard and concern - Identify sources (decisions, actions, people) of successful recovery maintenance - Identify positive consequences of recovery - Praise success - Maintain routine check-up schedule
Instability/distress, no alcohol/drug use but high risk of relapse (e.g. cravings, thoughts of using)	- Expressions of regard and concern - Elicit positive effects of sobriety and potential negative consequences of returning to AOD use - Intensify peer recovery supports - Enlist support from significant other - Explore option of contact with professional helper - Linkage to sober living environment - Increase check-up contact in next 30 days
Slip with return to abstinence	- Expressions of regard and concern - Evaluation of the slip (and lessons learned) - Evaluation of the strength of peer recovery supports (Re-linkage or linkage to alternative group) - Elicit positive effects of sobriety and potential negative consequences of sustained return to AOD use - Elicit recommitment to recovery - Increase frequency of check-ups for next 60 days to verify recovery stability
Alcohol/drug use without reported negative consequences	- Expressions of regard and concern - Review of past consequences of AOD use - Evaluate abstinence goal and client's commitment to continue AOD use or return to sobriety goal - Elicit positive effects of sobriety and potential negative consequences of sustained return to AOD use - Explore earliest ways client would know that AOD use was becoming a problem again - Enlist significant other in monitoring and support - Option of re-linkage to peer and professional support - Apply test of moderation ground rules, e.g., Miller & Munoz, 2005 - Increase check-ups for next 90 days
Alcohol/drug use with negative consequences	- Expressions of regard and concern - Elicit duration and intensity of negative consequences and future problems if use continues - Elicit how these problems would change if sobriety re-initiated - Assertive linkage to peer recovery supports - Assertive linkage to professional supports - Support to family/significant other - Increase monitoring of response to peer and professional supports

A Brief Note on Early Re-intervention: In the routine process of post-treatment monitoring and assessing individual responses to post-treatment mutual aid involvement, counselors and recovery coaches will experience encounters in which the client is on the brink of lapse/relapse or has already experienced lapse/relapse. We would offer several points to consider regarding the process of early re-intervention. *First*, re-intervention is important because it provides a point of recovery restabilization when problem severity has not fully re-escalated and when the client still has recovery assets that can facilitate long-term recovery (assets that are depleted over time with re-addiction). The goals of re-intervention are to reduce the client's immediate threat of injury to self and others, shorten the length and intensity of the lapse/relapse experience and use the lapse/relapse experience to elevate the commitment to recovery and strengthen relationships with the community of recovery.

Second, many clients experience intense shame following relapse and that shame is a major barrier to recovery restabilization. That shame can be diminished by providing normative data on relapse and recovery, praising the continued commitment to recovery, and re-affirming the recovery support partnership. *Third*, not everyone who lapses or relapses needs readmission to primary treatment. Those who do need treatment may not need the same level of care they most recently experienced. The problem may lie, not in the mechanics of recovery initiation, but in the transition from recovery initiation to recovery maintenance in the client's natural environment. The focus should be on building recovery supports into this environment to facilitate the development of a sobriety-based lifestyle and skills in the sobriety-based resolution of problems in daily living. Thus, a call to a sponsor and re-linkage to a support group may be more appropriate than readmission to treatment for some clients. Where treatment is needed, that linkage process must be direct rather than simply verbal encouragement. *Finally*, while post-treatment re-intervention is part of the process of sustained recovery management, the clinical strategies contain many of the elements essential to effective brief interventions: empathy, feedback, emphasis on personal responsibility, clarification of choices, professional advice, and expressions of confidence in client's ability to change (Miller and Rollnick, 1991).

Styles of Long-term Recovery Mutual Aid Affiliation: It is important to understand the varieties and styles of recovery maintenance and the evolution of these styles over time. For example, everyone who stops regularly attending recovery support meetings is not on the verge of relapse and re-addiction. A recent study of patterns of A.A. attendance concluded that, "contrary to A.A. lore, many who connect only for a while do well afterwards" (Kaskutas, et al, 2005). This does not diminish the importance of A.A.; in fact, it suggests measuring the impact of A.A. and other recovery support groups solely by current membership statistics results in a gross underestimate of the total contributions such groups make to addiction recovery. While some people will need or profit from lifelong attendance at A.A. meetings, others will disengage from or decrease meeting participation while sustaining stable recovery. Research on what distinguishes the "maintainers" from the "disengagers" is limited; we suspect that cumulative studies will reveal that the former are made up of those with addictions of greater

severity and complexity and fewer recovery supports, as well as people who shift the primary focus of their recovery group participation to social fellowship and spiritual development. Recovery stability and vulnerability for relapse must be measured by looking at the whole person and their recovery environment, rather than solely on meeting attendance or non-attendance.

Linkage Skills: A Brief Review

To bring these discussions to closure it might be helpful to briefly review the core knowledge and skills that addiction counselors and recovery coaches require to perform the services we have described. Those critical skills include:

- developing and sustaining a supportive, non-exploitive, recovery-focused relationship with each individual and family seeking services,
- assessing each client, family and community's recovery capital and recovery resource needs,
- remaining aware of all national and local recovery support resources,
- empowering each client to make choices related to his/her recovery pathway/style,
- maintaining relationships with key individuals/groups within local communities of recovery,
- matching the needs and preferences of clients to particular recovery support resources,
- Linking (guiding into relationship with) each client to an identified person/group,
- Monitoring each person's response to a chosen pathway/style of recovery and their need for amplified clinical or peer-based recovery support resources,
- Offering feedback and support related to recovery pathway/style choices,
- Providing, when needed, early re-intervention and recovery re-initiation services, and
- Facilitating the development of needed recovery support resources.

Summary

In this essay, we have tried to:

1) describe the emergence of a recovery paradigm as a new organizing concept for treatment and recovery support services,
2) summarize the scientific evidence supporting post-treatment check-ups and assertive linkage to peer-based recovery support groups,
3) describe the growing diversity of American communities of recovery,
4) outline strategies for building/strengthening relationships between treatment organizations and local recovery societies, and
5) offer suggestions on how, within a larger framework of post-treatment monitoring and support, addiction counselors and recovery coaches can link individuals/families to recovery support groups.

It is our hope that this effort adds momentum to the movement to shift addiction treatment from an acute care model to a model of sustained recovery management.

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Appendix A

Resources to Contact about How to Organize a Recovery Community Center

Asian Pacific American Community Recovery Network (ACORN)
Kelly Thao, Community Outreach Specialist
720 8th Avenue South, Suite 200
Seattle, WA 98104
(206) 695-7649
kellyt@acrs.org

Connecticut Community for Addiction Recovery (CCAR)
Phillip A. Valentine, Executive Director
530 Silas Deane Highway, Suite 220
Wethersfield, CT 06109
(860) 571-2985
phillip@ccar.us
http://ccar.us/

Detroit Recovery Project (DRP)
Andre Johnson, Program Manager
1151 Taylor Street, Room 417C
Detroit, MI 48202
(313) 876-0770
Easy Does It, Inc.
Dave Reyher, Executive Director
1300 Hilltop Road
Leesport, PA 19533
(610) 373-2463
dreyheredi@comcast.net

El Paso Alliance
Ben Bass, Executive Director
6000 Welch No. 7
El Paso, TX 79905
Phone: 915-594-7000
http://www.recoveryalliance.net/
BBass@RecoveryAlliance.net

Friends of Recovery - Vermont (FOR-VT)
Patty McCarthy, Executive Director
PO Box 1202
Montpelier, VT 05601
(802) 229-6103, 1 (800) 769-2798
RecoveryVT@aol.com http://www.friendsofrecoveryvt.org/

Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT)
Bev Haberle, Project Director
Women's Community Recovery Center
Bailiwick Office Complex, Suite 12/14
Doylestown, PA 18901
(215) 345-6644
Bhaberle@bccadd.org

Recovery Association Project (RAP)
Kathy Brazell, Executive Director
1100 NE 28th Avenue, Portland, OR 97232
(503)493-9211 Fax (503)493-9249
www.rap-nw.org
kb@rap-nw.org

RECOVER Project
Laurie Kamansky, Project Manager
55 Federal Street, Suite 125
Greenfield, MA 01301
(413) 774-5489
lkamansky@wmtcinfo.org

Walden House, Inc.
Demetrius Andreas, Project Director
149 West 22nd Street
Los Angeles, CA 90007
(213) 741-3731
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About the Authors

William White is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* and *Pathways from the Culture of Addiction to the Culture of Recovery*.

Ernie Kurtz's books include *Not-God: A History of Alcoholics Anonymous* and *The Spirituality of Imperfection* (with Katherine Ketcham).

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Recovery-related Studies / A Selected Bibliography

March 25, 2006 — William L. White, M.A.

Introduction

This topical bibliography is intended as a supplement two monographs: *Recovery Management* (co-authored with Ernest Kurtz and Mark Sanders), developed for the Great Lakes Addiction Technology Transfer Center, and, *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches* (co-authored with Ernest Kurtz), developed for the Institute for Research, Education and Training in Addictions and the Northeast Addiction Technology Transfer Center. It is hoped this will help interested readers locate what I consider to be classic and important contemporary papers related to the resolution of alcohol and other drug problems. A good beginning source (because of its review of much of the research cited below) is the following: White, W. & Kurtz, E. (2005). *The Varieties of Recovery Experience*. Chicago, IL: Great Lakes Addiction Technology Transfer Center (Posted at www.glattc.org).

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2006). The Voice of History: Sponsorship and peer-based recovery support services. Recovery Rising: *Quarterly Journal of The Faces and Voices of Recovery*, Winter Issue, pp. 7-8. Posted at **www.williamwhitepapers.com**

Sponsorship and Peer-based Recovery Support Services (P-BRSS)

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Historically, there are 5 types of P-BRSS: 1) mutual support within addiction recovery mutual aid societies (e.g., sponsorship rituals in A.A.), 2) people in recovery working in non-clinical roles to provide pre-treatment and in-treatment recovery support (e.g., as outreach workers, detox techs, house managers, case managers), 3) people in recovery working in clinical roles in primary addiction treatment (e.g., as addiction counselors or as physicians, nurses, psychologists or social workers), 4) people in recovery providing person/family-focused recovery support services after primary treatment, and 5) people in recovery working as systems change agents (e.g., as community organizers, educators, policy advocates). While such roles date from the 18th and 19th centuries, they have expanded dramatically in recent years. The proliferation of paid recovery support specialists (e.g., recovery coaches, personal recovery assistants, etc.) is a point of some controversy within communities of recovery.

One issue of concern is, "If there are sponsors (SP), why is there a need for a recovery coach (RC)?" In spite of key similarities between these roles (e.g., their recovery focus and service relationships grounded in moral equality and emotional authenticity), there are marked differences. Where the SP works within a particular framework of recovery (e.g., a Twelve Step program), the RC is trained to work across the span of religious, spiritual and secular frameworks of recovery. Where the SP is free and even expected to impose his or her view of recovery on the sponsee, the RC refrains from imposing such biases and is guided instead by a choice philosophy that recognizes the legitimacy of multiple pathways of recovery. Where the sponsorship relationship is based on reciprocity (the sponsor is there first and foremost to strengthen his or her own sobriety), the RC relationship is based on a fiduciary relationship in which the RC has a legal and ethical obligation to those receiving RC services. Compared to the sponsor role, most recovery coaches have more hours available per week to devote to recovery support services, work with a larger number of people at a time, perform duties that far

transcend traditional sponsorship roles, are involved in activities that would be specifically precluded as a sponsor (e.g., advocacy) and are guided by organizational codes of ethics and professional supervision.

A second question of concern is, “Couldn’t the existence of paid recovery coaches potentially undermine the service ethic within local recovery support groups?” The answer here is, “Absolutely!” P-BRSS must be an adjunct to the recovery supports provided by recovery mutual aid societies, not a replacement of those supports.



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Citation: Godley, S. & White, W. (2006). Student assistance programs: A valuable resource for substance-involved adolescents. *Counselor*, 7(2), 66-70. Posted at **www.williamwhitepapers.com**

Student Assistance Programs: A Valuable Resource for Substance-involved Adolescents

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Many schools attempted to forge a systematic response to growing alcohol and drug-related problems in the 1960s and early 1970s. At their best, these responses combined primary prevention and early intervention activities with strong linkages to adolescent treatment resources and the development of school-based recovery supports during and following treatment. In the mid-1970s, these activities were integrated within a growing network of student assistance programs (SAPs). In the intervening years, SAPs have:

- evolved into a professional field (via the National Student Assistance Association),
- developed different models for delivering SA services (e.g., core team model, in-house counselor model, external SAP model, eclectic model) (Love, 2005),
- extended their focus from alcohol and drugs to an ever-widening net of student problems,
- expanded from high schools to middle and elementary schools, and
- moved towards a philosophy of evidence-based practice (Ferlman, Tarasevich, & Helper, 2003).

A growing body of research on adolescent substance use underscores the importance of SAPs and their collaboration with community-based treatment agencies. Studies revealing that early age of onset of substance use increases the risks for developing severe substance use disorders dramatize the importance of school-based programs that can prevent or postpone substance exposure (Grant & Dawson, 1997). The finding that an intervention at an early age can shorten an addiction career confirms the importance of early intervention services (Dennis, Scott, & Funk, 2005). Equally important are the findings that there are effective, manual-guided therapies for the treatment of adolescent substance use disorders (Dennis, Godley et al., 2004) and that assertive post-treatment monitoring and support elevate long-term adolescent recovery outcomes (Godley, Godley, Dennis, Funk, & Passetti, 2002).

Rigorous evaluations of the effectiveness of SAP programs have been limited, but more recently NIH funded studies have

tested interventions designed for this setting (Wagner, Tubman, & Gil, 2004; Winters & Leitten, in press). One model of delivering SAP services involves a collaborative partnership with a community-based treatment program and local schools that utilize evidenced-based interventions to enhance the continuum of care for adolescents in the school and the community. To illustrate the process and outcomes of this type of collaboration, this article will describe the implementation and evaluation of an external SAP that combines the resources of a community-based prevention and treatment agency with 23 schools and note the implications of these findings for addiction counselors.

Overview of the Services

Chestnut Health Systems, a community-based behavioral health care provider in Illinois, has provided student assistance services to schools on a contractual basis since 1985. In the Central Illinois region, this service has grown to 11 SAP staff serving four elementary schools, nine junior high schools, and 10 senior high schools. Traditionally, the types of services provided included crisis intervention, screening and assessment, referral for mental health or alcohol or other drug problems, facilitation of support groups, class presentations, consultations with teachers, staff, and parents, and brief interventions. However, there was not standardization for the screening and assessment activities or for the brief interventions, nor was there training or supervision in the use of a specific screening instrument or intervention model. A federal grant from the Center for Substance Abuse Treatment provided the impetus to introduce more standardized, evidence-based practices.

Screening. The first activity to be standardized across all junior and senior high schools was the use of the Global Appraisal of Individual Needs-Quick (GAIN-Q; Titus & Dennis, 2005), a screener that takes 20 to 30 minutes. One of the qualities of the GAIN-Q that SAP counselors like is that it not only screens for substance use, but also for other behavioral health problems including depression, ADHD, and sources of stress. Most SAP staff use an electronic version that generates a narrative referral and recommendation summary from the screening data. Possible screening recommendations include (a) a longer, more detailed assessment, (b) a brief intervention, or (c) other possible referrals to consider. For adolescents who endorse substance use during the screening, a Reasons for Quitting Scale (RFQ) is also administered so that the answers can be used later in the brief intervention. See http://www.chestnut.org/LI/gain/GAIN_Q/index.html for more information about the GAIN-Q.

One of the first challenges staff raised during implementation of the GAIN-Q was determining which students would be screened. Students served by SAPs run the gamut from those stressed out because they cannot find their locker to those who are suicidal. SAP counselors were concerned about possibly providing more screening services than needed for a student who had a relatively minor crisis or making a student sit through a 20-minute screening when he or she was in a serious crisis situation. The planning team decided a student had to be seen at least two times to warrant use of the screener. This approach allows for a later screening of those students who are in a major crisis during their initial referral. During the most recent school year, 443 GAIN-Qs were completed in the 23 schools served by Chestnut SAP counselors.

Intervention. When a student reveals substance use and associated problems, there are two possible recommendations. Those students with little use or associated problems are asked to participate in a five-session Motivational Enhancement Therapy/Cognitive Behavior Therapy (MET/CBT5) at the school with the SAP counselor. If the reported problems are more severe, the student is referred for an in-depth assessment at the school or at a treatment facility to determine if more

intensive treatment is warranted. In most situations, parents are not aware that a student has been referred to or screened by SAP. In the case of a comprehensive assessment, students are told that their parents will be informed and this, along with a reluctance to participate in traditional treatment, leads many students to opt out of the more comprehensive assessment. If students refuse further evaluation, they are then approached about participating in the brief intervention. Support for this approach is based on research suggesting that brief motivational enhancement approaches can in and of themselves be effective treatment or have the potential to move the adolescent along the stages of change continuum, so that he or she may be more open to longer and more intensive treatment at a later time.

MET/CBT5 is a manual-guided approach (Sampl & Kadden, 2001) that was evaluated in the Cannabis Youth Treatment study (Dennis, Godley et al., 2004) and found to be effective at reducing substance use and problems. The manual describes group delivery of the CBT portion of the intervention, but in the SAP application, it is provided in individual sessions. SAP counselors vary time frames for each session as needed to fit with school schedules and add additional sessions if needed to cover the necessary material.

As described in the manual, the first session is designed to develop rapport with the student, build motivation, provide educational material, and review the personalized feedback report produced during the screening interview. During the second session, the SAP counselor works with the student to set goals and guides the student through a functional analysis of his or her alcohol or drug use. During the subsequent three sessions, students are taught refusal skills, how to enhance their social support, and coping with high-risk situations. After explaining each skill, the student is asked to practice it in session and to complete some mutually-agreed upon practice in a real life situation before meeting with the SAP counselor. Throughout all five sessions, the SAP counselor is expected to use the five strategies of MET: Expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy.

Check-In Sessions After MET/CBT5. During the first year of implementation, SAP counselors raised a concern about students who completed the five-session intervention and were still unwilling to quit using alcohol or other drugs or attend further treatment at a treatment agency. To address this situation, a post-counseling check-in procedure was developed. There is a greater likelihood of compliance with continuing care in a school setting than in a traditional clinic. When students complete MET/CBT5, SAP counselors schedule check-in appointments at least once per month for three months. More frequent appointments are scheduled if the SAP counselor determines that increased contact is needed. For students who are invited to participate in MET/CBT5 and stop attending sessions before they complete the intervention, SAP counselors schedule at least one check-in appointment during the three months after the student stops attending MET/CBT5. For all students identified with alcohol and drug concerns, the SAP counselor schedules a check-in appointment at the beginning of the next school year and completes a GAIN-Q rescreening annually.

During the check-in session, the SAP counselor administers the Happiness Scale (HS) from the Adolescent Community Reinforcement Approach Cannabis Youth Treatment manual (Godley et al., 2001). The HS is a one-page form that covers 16 life areas (e.g., substance use/non-use, school, relationships with friends) that students rate on a one-to-ten scale indicating their degree of satisfaction with each dimension. The HS helps communicate a holistic interest in the student (not just in substance use) and provides an easy entrée into different areas of his or her life. SAP counselors review the HS with each student and work to develop goals.

Continuing Care for Students in or Discharged from Treatment. Students also need support or continuing care services when they are currently attending or have been discharged from treatment. One of the advantages of the CSAT-funded grant was that an electronic clinical and case management record was developed, which allows electronic notification to an SAP counselor that a student attending his or her school has been discharged from treatment. This system also allows the SAP counselor to view the student's progress during treatment. Since the SAP counselor is made aware of a student's participation in or discharge from treatment, he or she can call the student in for a check-in session and see him or her as frequently as needed using the Happiness Scale procedure and other MET/CBT procedures. These students are also scheduled for annual screenings with the GAIN-Q.

Staff Training and Monitoring

The transfer of evidence-based practices from controlled studies to implementation in applied settings is challenging and requires investing resources in staff training, certification, and on-going monitoring. The first and foremost barrier to overcome is resistance to change existing SAP service delivery methods. The first step in overcoming this resistance is to provide an explanation outlining the reasoning for proposed changes and data supporting the new approach. There are also advantages to a gradual implementation of new procedures. The three-year implementation process used at Chestnut provided the opportunity for those who were trained first to spread their new knowledge and enthusiasm to those who were trained later.

SAP counselors' competency in administering the GAIN-Q and delivering MET/CBT5 was achieved through training, certification, and supervision. GAIN-Q training was based on the GAIN Coordinating Center requirements, which involve training, practice with feedback, taped administrations reviewed by quality assurance specialists who give written feedback until certification is attained, followed by periodic taped reviews. A similar process is employed for training and monitoring staff in MET/CBT5. After training by an expert in MET/CBT, SAP counselors are required to tape sessions (with students' permission) for review by the supervisor. SAP counselors also use session check sheets from the intervention manual as a means of self-feedback to ensure they are following procedures. As with the GAIN-Q, once SAP counselors are certified in the use of MET/CBT5, the frequency of tape review is reduced. Another aspect of weekly supervision is the examination of each SAP counselor's 'case review log', which provides a row for each student and shows starting date, number of sessions, and a column for each MET/CBT procedure. This log allows clinical supervisors to quickly assess the status of every student receiving MET/CBT. Group supervision is also provided twice a month so that counselors can learn through a group tape review process and discuss common issues.

To ensure that SAP program managers know each individual and school's level of implementation, it is necessary to collect performance indicator data on both the screening and assessment process by the SAP counselor and school. Indicators include (a) type of SAP referral (new, call back by the counselor, walk-in, from the treatment agency), (b) reasons for referral, (c) placement recommendations, (d) number referred and completed for a more in-depth assessment, (e) average number of days from referral to completed GAIN-Q, and (f) number beginning and completing MET/CBT5. Pre and post-outcome data are also collected using the GAIN-Q to guide program improvement. For example, in the first year, outcome findings suggested that the percentage of students reporting marijuana use decreased after the intervention, while there was an increase in the percentage of MET/CBT students who reported binge drinking. This finding suggested the need for SAP counselors to focus more of their attention and the educational materials on alcohol and binge drinking.

Working with the Schools

School district superintendents and school personnel like the standardized screening and the manual-guided intervention because they are similar to professional tools they use (e.g., standardized tests and curriculum). In the beginning, presentations were made as requested to school boards, superintendents, and school counseling and social work teams to describe the planned changes in the SAP program. Last year, a major emphasis was to ask all the school districts in the county to consider adopting similar policies for alcohol and drug infractions that would encourage student participation in the intervention for those who need it. The proposed policy included a reduction in suspension time if the student participated in the GAIN-Q screening and MET/CBT5, and the parent(s) met with the SAP counselor at the beginning and the end of the process.

Lessons Learned

One of the advantages of using the GAIN-Q is that it provides data that can be used for program improvement. Table 1 shows the similarities and differences between adolescents seen in a school setting for MET/CBT and those seen in outpatient treatment. SAP participants are significantly more likely to be female and younger, while adolescents seen in treatment are more likely to have been arrested in the past year and African American. There were no significant differences with regard to prior treatment for a substance use disorder in the past year. Most significantly, adolescents in treatment do not appear to necessarily have more severe substance use problems than those seen in the SAP; but they are older, more likely to be male, and more likely to have been involved in the juvenile justice system. These data provide support that services in schools offer the possibility for earlier intervention.

Outcomes have been evaluated to the extent possible with pre- post- data analysis (Figure 1). Student's initial GAIN-Qs are used as pre-tests and their post-tests are a follow-up version of the GAIN-Q (administered by research assistants to reduce respondent bias) 90 days or more after their screening. When combining the data across three years of implementation, there are significant decreases in the percentage of these students reporting any alcohol, marijuana, and other drug use.

SAPs and the Addictions Professional

This brief summary of the contractual delivery of SAP services by a community-based treatment agency underscores the growing role addiction professionals are playing in the delivery of school-based early intervention and post-treatment support services to substance-involved adolescents. This work is being guided around the country by new models of institutional collaboration, more effective screening instruments, the integration of evidence-based and manual-guided intervention protocol, and a commitment to the continued evaluation and improvement of school-based early intervention and support services. We envision a future in which addictions professionals will play an increasingly important role in the design and delivery of such services and the ongoing refinement of these interventions to create even more potent effects.

Acknowledgements

The authors would like to acknowledge the Student Assistance Program staff of Chestnut Health Systems and the many school districts, superintendents, and school administrators in Central Illinois who have helped make this a successful collaboration. In particular, we would like to acknowledge the contributions of Loree Adams, Bruce Boeck, Rod Funk, Mychele Kenney, Lora Passetti, Rick Risberg, Kimi Schroeder, and Kelli Wright for their leadership during implementation, data collection, and analysis.

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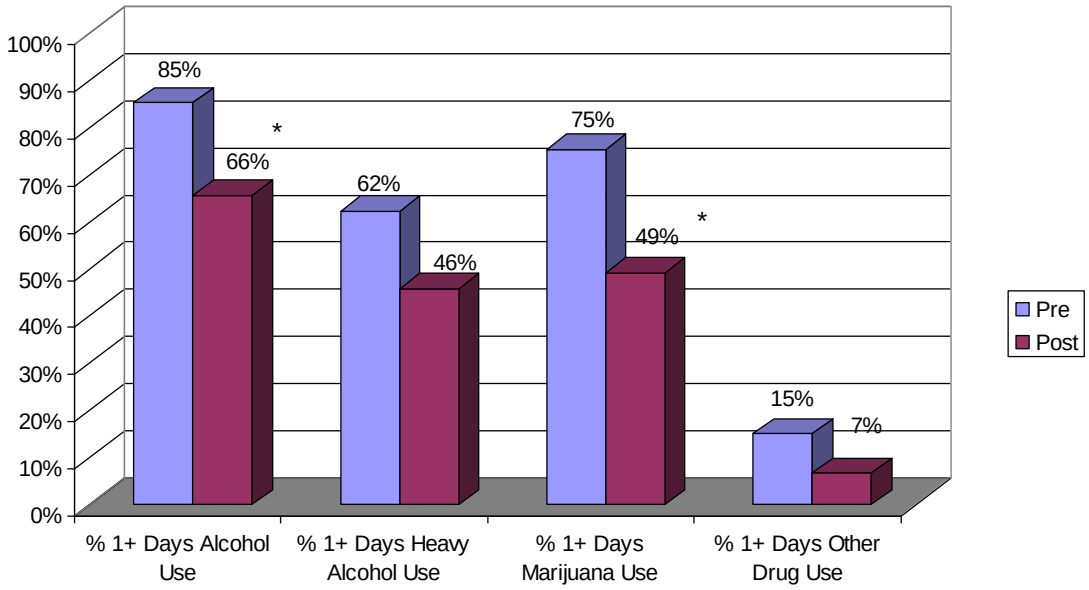
Table 1. Demographics by SAP vs. Outpatient Treatment

Demographics	Youth in SAP (n=61)	Youth in Outpatient Treatment (n=75)
Female\a	54%	29%
African American\a	2%	8%
Caucasian	77%	76%
Hispanic	0%	5%
Mixed/Other	21%	11%
11 - 14 Years Old\a	41%	15%
15 – 16	39%	61%
17 – 18	20%	24%
Any Prior Mental Health Treatment	61%	54%
Any Prior Substance Abuse Treatment	16%	11%
Arrested in the Past Year\a	12%	62%
Any Past Year Substance Disorder\b	71%	85%

a\ Chi-square difference is significantly different ($p<.05$)

b\ Abuse or dependence

Figure 1
Substance Use for MET/CBT5: Years 1 - 3
N=61



* Signifcant difference, p<.05 (McNemar)

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Recovery:
A Conceptual Bridge Between the Mental Health and Addictions Fields

By William White, MA and Larry Davidson, PhD

During the late nineteenth century, conflict flourished between leaders of the Association of Medical Superintendents for American Institutions for the Insane (AMSAII) and leaders of the American Association for the Study and Cure of Inebriety (AASCI). Members of both groups represented institutions and practitioners plagued by the confluence of addiction and mental illness. Chicken or egg arguments on the relationship between the two disorders abounded, as did debates about cultural/ professional ownership of the most intractable clients and their appropriate diagnosis and treatment (Deutsch, 1937; White, 1998). From this inauspicious beginning, an uneasy relationship between the addictions and mental health fields has evolved, marred by sustained conflict, competition, mutual antipathy, and failed service integration efforts followed by re-segregation of the fields. Pockets of successful behavioral health service integration at the local level within this history have been obscured by the overall bifurcation of behavioral health into separate addictions and mental health fields.

A recovery revolution is now occurring within and across the addictions and mental illness problem arenas that challenge practices within both of these fields as well as their historical segregation. This paradigmatic shift will fuel debate over whether this recovery revolution is a long-awaited and desperately needed opportunity to revitalize, or a cataclysm that will de-professionalize and then destroy, both fields. The purpose of this brief essay is to explore whether the concept of recovery could serve as a conceptual bridge through which the treatment of addiction and mental illness could be integrated within one recovery-oriented system of care. The authors speak as long-tenured insiders within these respective fields whose writings and presentations advocate embracing this revolution in thinking and practice (e.g., White, Boyle & Loveland, 2004; White, 2005; White, 2006; Davidson,

O'Connell, Tondora, Staeheli & Evans, 2005; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Davidson, Stayner, Nickou, Stryon, Rowe & Chinman, 2001; Davidson & Strauss, 1992, 1995).

Service Integration: Inhibiting and Promoting Forces

A review of the histories of the addictions and mental health fields provides three clues on why past service integration efforts may have failed. First, efforts to integrate the treatments of addiction and mental illness have failed when they focused on discussions of the etiology or nature of these disorders or on treatment philosophies and techniques. Historically, common ground for behavioral health integration does not lie in these arenas, although advances in neurobiology may yet establish such common ground. Second, practitioners from both the addictions and mental health fields have been unprepared and often unwilling to treat clients from their sister field. The relationships between addiction treatment providers and clients with severe mental illness and the relationships between mental health service providers and those with severe alcohol and other drug problems both have been characterized by institutionalized counter-transference (e.g., lack of empathy, disrespect, contempt, exclusion, and extrusion). Service integration efforts have often failed to address these attitudinal barriers. Third, the historical conflict that has pervaded the relationship between theses two fields is imbedded in prolonged competition for scarce resources, fears regarding the loss of institutional and professional legitimacy and integrity, and structural issues at the national level that drive segregated policies, funding streams, and regulatory oversight. Without a strong and shared conceptual foundation, the processes involved in service integration experiments have occurred largely by administration fiat and were often experienced at the front lines as one field attempting to colonize the resources of the other.

What is surprising in light of this history is the continued discussion regarding the potential advantages of an integrated behavioral health system. The forces pushing integration appear to be just as significant as those inhibiting it. People experiencing addictions and those with severe mental illness have often been considered hopeless and been the target of intense social stigma manifested in their sequestration in almshouses, decaying asylums, jails, and prisons, or abandoned on the nation's streets. There is in this shared history a sense that the fate of individuals and families impacted by mental illness and addiction may be somehow linked, and that joint efforts might lead to more progress than isolated efforts.

Adding to the weight of this history is the growing confluence of these problems. Epidemiological and service utilization data reveal that these problems are as likely to co-occur in the same individuals and families as to exist independently of one another. Over the past two decades, an extensive body of literature has illuminated the poor quality of care individuals and families with multiple problems receive within the current system of categorically segregated services. That body of research is confirming the superior outcomes achieved within integrated models of care. All of these factors add momentum to service integration initiatives, but we suspect the primary spark for such integration will come from another source. The individuals and families experiencing these problems and the lived solutions they are discovering suggest new rationales and strategies for service integration that have hitherto escaped policy makers, managers, and practitioners.

The Recovery Revolution

There is a shift within the broad arena of behavioral health from pathology and treatment paradigms to one of recovery (White, 2005). This shift is indicated by:

- The growth and diversification of recovery mutual aid structures (support groups, clubhouses, recovery support centers, recovery housing, recovery educational programs, recovery job co-ops)
- The growth in grassroots recovery advocacy organizations in both fields that are addressing the problem of co-occurring disorders at both clinical and organizational levels,
- Major policy reports, including the President's New Freedom Commission Report on *Achieving the Promise (2003)*, SAMHSA's *Transforming Mental Health Care in America* (2005), and the National Institute of Medicine's *Improving the Quality of Health Care for Mental and Substance-use Conditions (2006)*.
- New pilot initiatives at the Federal level (CSAT's Recovery Community Support Program and Access To Recovery), and state- and city-initiatives (e.g., CT, Philadelphia) to integrate behavioral health care within a recovery-focused system transformation, and
- Significant increases in number and quality of scientific studies on the pathways and processes of long-term recovery from addiction and from mental illness.

"Recovery-oriented system transformation" is becoming an umbrella concept for integrating behavioral health care and creating systems of care that are culturally competent, trauma-informed, evidence-based, inclusive of families, based on strengths, and connected to communities (as indigenous sources of recovery support). Leading the call for such system transformation are new recovery advocacy movements in both the addictions and mental health fields. These movements, led by people in recovery, their families and visionary professionals, are demanding that care be focused on the processes of long-term recovery and anchored within natural supports and local communities.

Core Ideas

Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction tap resources within and beyond the self to move beyond experiencing these disorders to actively managing the disorders, managing their residual effects and building full, meaningful lives in the community. Recovery is more than the elimination of symptoms from an otherwise unchanged life; it is about regaining wholeness, connection to community, and a purpose-filled life. There are a number of over-arching ideas that are at the core of these new recovery advocacy movements.

1. Recovery is a reality in the lives of millions of individuals and families.
2. There are many pathways and styles of recovery.
3. Recovery is a voluntary process.
4. Recovery flourishes in supportive communities.
5. Recovery gives back (to individuals, families, and communities) what addiction and mental illness have taken away.
6. Behavioral health care must move beyond emergency and palliative care to care that is oriented to promoting long-term recovery.

Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in long-term support of the person's/family's own recovery efforts. Recovery-oriented care shifts the design of the addiction treatment system from an acute care model focused on serial episodes of biopsychosocial stabilization to a model of sustained recovery management. That same recovery orientation in the mental health field shifts the service design beyond cyclical crisis intervention and "sustaining care" aimed at symptom suppression and reduced

hospitalizations to one of recovery enhancement. Recovery-oriented care focuses on the acquisition and maintenance of recovery capital (internal and external assets required for recovery initiation and self-maintenance), global health (physical, emotional, relational, and spiritual) and community integration (meaningful roles, relationships, and activities).

Understanding that system change, like recovery, must be led by people with lived experiences of recovery, the Connecticut Department of Mental Health and Addiction Services consulted with statewide recovery advocacy organizations to develop a set of core recovery values (e.g., self-sufficiency, dignity, respect) and principles to drive their system transformation process. These principles included the following admonitions: 1) f*ocus on people rather than services,* 2) m*onitor outcomes rather than procedural performance,* 3) e*mphasize strengths rather than deficits or dysfunction*, 4) e*ducate the public to combat stigma*, 5) *foster collaboration as an alternative to coercion, and 6*) p*romote autonomy and decrease reliance on professionals* (Recovery Resource Guide, 2002).

Transforming Practices

As we have watched and helped facilitate these experiments in system transformation in states like Connecticut and cities like Philadelphia, we have been struck by the broad changes in practices in both mental health and addiction agencies that unfold as an outcome of recovery-focused system change. Some of the most profound of these changes occur in the following areas (White, Boyle & Loveland, 2002):

- Roles of clients, families, and recovery advocates: Shifts from viewing people with mental illnesses or addictions as the problems a system has to deal with to viewing people in recovery as valuable assets and partners, with their involvement at all levels of service organization and across major functions (policy development, planning, service delivery, service evaluation) in advisory, volunteer, and paid roles; decision-making viewed as crucial to long-term recovery; and a philosophy of choice guides all levels of care and nuanced across developmental stages of recovery.
- Identification, engagement, and retention: Assertive outreach programs, shift from pain-based to hope-based intervention strategies, lowered thresholds of admission, increased use of case management to resolve obstacles to participation, and use

- Assessment: Shifts from assessment protocols that are categorical (specialized), pathology-based, individual-focused, and an intake function to assessment protocols that are global, strengths-based, family-centered, and continual.
- Service Goals: Symptom reduction/remission shifts from a goal to a strategy; goals focus on quality of life, achievement of personal aspirations, meaningful participation in and service to the community.
- Service planning and service team: Rapid transition from professionally-directed treatment plans to client-driven recovery plans; move to multi-agency, interdisciplinary service models; inclusion of family and indigenous healers (clergy, folk healers, recovery peers, e.g., sponsor) in treatment and recovery planning process.
- Role of the Community: Emphasis on local recovery education and policy advocacy; shift from viewing community as context for or precipitant of relapse to reservoir of resources, hospitality, and support; focus on collaboration with existing recovery support resources and community development strategies to expand the scope and quality of such resources.
- Service Timing: Shifts from crisis-based contact to long-term support focused on critical windows of peak functioning (to acknowledge and celebrate recovery) and critical windows of vulnerability (to provide support through situations that pose risk of relapse); use of regular recovery checkups.
- Locus of Service Delivery: Shifts from institutional environments to client's natural environment; considerable focus on the "ecology of recovery" (helping clients create a recovery-conducive physical and social environment).
- Service Relationship: Shifts from an expert model of diagnosis and treatment to a sustained heath care partnership; shifts from relationship that is hierarchical, transient, and highly commercialized to one that is less hierarchical, sustained, and natural; increased use of peer-based models of recovery support.

- Service Evaluation: Significantly involves clients, family members, and community elders in the evaluation process; emphasis shifts from pathology measures to key recovery indicators; shift from evaluating discrete service episodes to evaluating impact of service combinations and sequences on person's overall life over time.

Toward a Recovery-Oriented, Integrated System of Care

A move toward a more recovery-oriented system of care can occur concurrently and independently with the addictions and mental health fields or it can be used as an opportunity to move towards an integrated system of behavioral health care. We have been frankly surprised at the amount of common ground that is being discovered as recovery advocates from both fields have come to know each other and share their respective stories and concerns. In working with those systems that are attempting behavioral health integration, we have been similarly struck by the discovery that the greatest obstacles to integration are coming at structural levels (the segregation of policy development, service planning, funding, documentation requirements, and regulatory monitoring) and not at the front-line service levels. It is tragically ironic that the infrastructures put in place separately within both fields with a vision of enhancing quality of care now constitute obstacles in achieving that goal.

The structural obstacles to behavioral health care integration are substantial, and only sustained advocacy and new organizing constructs are likely to overcome these obstacles. The collaboration and growing influence of grassroots mental illness and addiction recovery advocacy groups and their progressive elaboration of the recovery concept may well provide the momentum for service integration and the conceptual bridge between the addictions and mental health fields. There is much potential synergy if this continues to unfold. To cite just one example, the addictions field has had a well-developed concept of full recovery for more than 200 years, but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but has, until very recently, lacked a viable concept of full recovery from severe mental illness. Neither field have had an understanding of "transcendent" recovery—a heightened level of personal and interpersonal functioning achieved as a result of having survived and transcended the limitations imposed by such severe and complex disorders (White & Kurtz, 2005). Both fields have much to gain from a dynamic interplay between these various views of recovery,

expanding the range of possibilities available to people living with these conditions.

The mental health and addictions fields have focused their collective energies on the study of pathology based on the assumption that discovering the etiological roots, natures, and courses of these disorders would generate effective treatments. Both fields are making substantial progress in the scientific evaluation of interventions designed to treat these disorders. But both fields are just beginning to build foundational knowledge on the prevalence, pathways, styles, and stages of long-term recovery. We envision a future in which behavioral health care will be designed based on intimate familiarity with and knowledge of the lived solutions to these problems. In that vision, two fields will have become one, and its primary message to the community will be one of hope for recovery from addiction and from mental illness.

Acknowledgment: Work on this article was supported in part by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

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Citation: White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58. Posted at **www.williamwhitepapers.com**

The Recovery School Movement: Its History and Future

William L. White, MA and Andrew J. Finch, PhD

For almost three centuries people recovering from severe alcohol and other drug problems have created sanctuaries for sharing experience, strength and hope. History suggests that when the vacuum of need reaches critical mass, recovering people, their families and visionary professionals coalesce into movements that birth new structures of recovery support. It is that exact process that birthed the recovery school movement in the United States. This article reviews the birth and evolution of recovery schools in the United States and suggests that the growing network of recovery schools is an important new resource for the individuals and families served by addiction professionals.

Birth of a Movement

The collegiate recovery school movement began with the development of school-based recovery support services at Brown University (1977) and Rutgers University (1983) and evolved into more fully developed recovery communities at Texas Tech University (Center for the Study of Addictions)(1986) and Augsburg College (StepUP Program)(1997). In the past five years, additional collegiate recovery programs have been organized at Dana College (2001), Grand Valley State University (2002), Case Western Reserve University (2004), University of Texas at Austin (2004), and Loyola College in Maryland (2004). Early pioneers in the collegiate recovery school movement included Bruce Donovan (Brown), Lisa Laitman (Rutgers), Carl Anderson (Texas Tech) and Don Warren (Augsburg College).

A second thread in the rise of recovery schools was the development of recovery support services for high school students and then the development of high schools exclusively for students in recovery. The first wave of recovery high schools opened between 1987 and 1998. These schools were truly experimental in nature, with the goal of "sober schooling" but no existing blueprints to guide them. Ecole Nouvelle (now Sobriety High) in Minnesota was established in 1986 and opened in a community center with four students and one teacher in 1987. Other early recovery high schools included several Minnesota schools: PEASE (Peers Enjoying a Sober Education) Academy (1989), the Gateway Program (1992), the Arona Campus (now Arona Academy) (1995), YES (Youth Education Sobriety) (1997, now closed), ExCEL Sober School (1998, now closed), and the

Aateshing Program (1998). Early programs outside Minnesota included Unity High School in Phoenix, AZ (1992, now closed), Recovery High School in Albuquerque, NM (1992, now closed), Phoenix Academy in San Mateo, CA (1992), Thoreau High School in Woodland Hills, CA (1996), Oasis Academy (now Community High School) in Nashville, TN (1997), Santa Rosa (CA) Clean & Sober High School (1998), and the Summit School in Spokane, WA (1998, now closed).

School founders included recovering persons who understood the need for school-based continuing care services, treatment professionals who had the training and foresight to create innovative schools; parents of recovering students who desired options for their children; and philanthropists and volunteers who were called to this new arena of community service. Some of early recovery high school pioneers included Ralph Neiditch, Carol Robson, and Konrad Friedemann (Ecole Nouvelle/Sobriety High), Barb Schmidt (PEASE Academy), Paul Grehl (Gateway), Rob van Kampen (YES), Mark Kuleta (Aateshing), Nichole Baum (ExCEL), LuAnn Woeltge (Arona), Judy Ide (Nashville Oasis Academy/Community High School), Nancy Tumosa (Phoenix Unity), Lou Sadler and Jan Hayes (Albuquerque Recovery High School). Lyle Taipale, with Sobriety High since 2003, helped establish two schools (Gateway and Arona) as a supervisor of alternative education in the St. Paul and Moundsview, MN, school districts.

In some cases, these pioneers helped conceive the idea and open the doors, and other leaders stepped in to keep the schools running and forge paths for other schools. Judi Hanson, Denise Martineau, and Jim Czarniecki helped Sobriety High expand to three campuses, and their assistance helped establish numerous recovery schools around the country. Similarly, Brad Kraushaar (Arona), Kellie Winter and Steve Massey (PEASE), Deb Seveland (ExCEL), and Ann Tash (Thoreau High School) helped their schools take root and set the stage for a rapid expansion of schools over the last few years. To date, the longest serving faculty member of any recovery school is Sobriety High's lead teacher, Larry Schmidt (1993-present). Schmidt, an English teacher, has developed curriculum designed specifically with the recovering teen in mind that he has shared with other schools and the professional treatment community.

The growth of recovery schools has been dramatic, with 25 recovery high schools and six collegiate recovery communities opening across the United States from 1999 to 2005. The recovery school movement was influenced by several important contexts: school choice policies, growth in alternative schools, the therapeutic community movement (of which recovery schools became an extension), the growth in adolescent chemical dependency programs (the first opening in Minnesota in the 1970s), and the growing recognition of the vulnerability for relapse for young people re-entering school following treatment. The inception of recovery high schools, also known as "sober schools", "dry highs", and "sobriety high schools", coincided with the adoption of school choice reform models in education policy. The idea that providing families with options within and outside the public sector would strengthen school accountability gave rise to legislation promoting alternative and charter schools, vouchers, and for-profit education companies. Minnesota and California were two of the first states to embrace school alternatives like charter schools and open enrollment policies, and notably, these were the first two states to open recovery high schools. This rapid recovery school growth spawned the Association of Recovery Schools, founded in 2002.

What is a Recovery School?

In the first decade, recovery high schools tinkered with policies and populations, addressing substance problems from initial intervention through the recovery maintenance phase. Most opened with a handful of students and only one or two teachers. The first college program at Brown offered confidential services to faculty and students, but was not a fully developed recovery community. As recovery high

schools and collegiate recovery programs have evolved, they have focused more specifically on forming communities for recovering students. Unlike the high schools, college programs are not school-wide, and their structures can vary widely depending upon the institution on which the program is located, the program umbrella under which the recovery community operates, the private or public funding of the school, and the size of the college or university. For this reason, most college programs are vastly different from each other. Some offer housing services, while others do not. Some offer specialized coursework, while others focus exclusively on therapeutic and general academic support. The high school programs, though offering differences themselves, are all-encompassing programs, and more commonalities exist across the 50 State education laws than are found in the thousands of college and university program umbrellas within which collegiate recovery communities are nested (Finch, 2005).

Recovery high schools enroll an average of 30-40 students. Each school requires students (a) to abstain from substance use and (b) to work a program of recovery from chemical dependency. Most, though not all, schools are based in the Twelve Step or Minnesota model of recovery. More than 95 percent of the students entering recovery high schools have received some form of treatment (residential and/or outpatient services), making recovery schools an important source of continuing care support following primary treatment. While some schools serve as transitional programs, all offer state-certified diplomas either directly or through their school districts. Unlike treatment facilities, education is a major focus, if not the main component, of recovery schools. They are essentially hybrids, serving both continuing care and academic goals (Finch, 2004). Virtually all of the schools operate as “day schools”, though many have close relationships with extended care residential treatment programs and halfway houses.

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One reason for such a spectrum of programming is the lack of foundational research and established best practices for recovery schools. Quantitative data on a national level is sparse, though many schools collect site-level data. For example, Community High School reports that at any point in time, 70-80% of its current students have not relapsed since enrolling. Though the schools enroll students who have often had truancy problems, recovery schools report attendance rates of 90-95% or better. Sobriety High tracks post-secondary matriculation of its graduates. The school reports that, since 1991, more than 65% of its graduates, most of whom were at-risk of dropping out while using drugs, have attended college. At the college level, an early evaluation of the collegiate recovery community at Texas Tech University found that its recovering students had a grade point average of 3.37 compared to an average of 2.68 for all undergraduates at the University, while maintaining a relapse rate of below five percent (White, 2001).

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Future of the Recovery School Movement

As with any policy innovation, funding, advocacy, and evaluation are needed for recovery high schools to continue expanding. While most receive some public support, almost all must supplement that income through private donations and grants. The other side of the growth has been school closures. At least one or two recovery high schools close each year, and of the 14 schools mentioned as foundational programs in this article, five are no longer recovery schools.

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Before the creation of the Association of Recovery Schools (ARS) in 2002, most recovery high schools, especially those outside Minnesota, developed in isolation. Thus, much remains to be learned about the structure and effectiveness of these programs. ARS has fostered communication and advocacy efforts, and it envisions:

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The expansion of recovery schools has far outpaced isolated recovery school closures, and public awareness about the schools has also been growing. These points offer hope for achievement of the ARS vision. However, just 12 states currently have a recovery high school or collegiate recovery community, and only the first steps towards establishing best practices have been taken. Although this vision is still many years from reality, recovery schools constitute an important new referral resource for addiction professionals. To best utilize those resources, addiction professionals will need to remain informed about the recovery school movement and play a critical role in forging relationships between treatment institutions and the growing network of recovery schools.

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Citation: White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58. Posted at **www.williamwhitepapers.com**

The Recovery School Movement: Its History and Future

William L. White, MA and Andrew J. Finch, PhD

For almost three centuries people recovering from severe alcohol and other drug problems have created sanctuaries for sharing experience, strength and hope. History suggests that when the vacuum of need reaches critical mass, recovering people, their families and visionary professionals coalesce into movements that birth new structures of recovery support. It is that exact process that birthed the recovery school movement in the United States. This article reviews the birth and evolution of recovery schools in the United States and suggests that the growing network of recovery schools is an important new resource for the individuals and families served by addiction professionals.

Birth of a Movement

The collegiate recovery school movement began with the development of school-based recovery support services at Brown University (1977) and Rutgers University (1983) and evolved into more fully developed recovery communities at Texas Tech University (Center for the Study of Addictions)(1986) and Augsburg College (StepUP Program)(1997). In the past five years, additional collegiate recovery programs have been organized at Dana College (2001), Grand Valley State University (2002), Case Western Reserve University (2004), University of Texas at Austin (2004), and Loyola College in Maryland (2004). Early pioneers in the collegiate recovery school movement included Bruce Donovan (Brown), Lisa Laitman (Rutgers), Carl Anderson (Texas Tech) and Don Warren (Augsburg College).

A second thread in the rise of recovery schools was the development of recovery support services for high school students and then the development of high schools exclusively for students in recovery. The first wave of recovery high schools opened between 1987 and 1998. These schools were truly experimental in nature, with the goal of "sober schooling" but no existing blueprints to guide them. Ecole Nouvelle (now Sobriety High) in Minnesota was established in 1986 and opened in a community center with four students and one teacher in 1987. Other early recovery high schools included several Minnesota schools: PEASE (Peers Enjoying a Sober Education) Academy (1989), the Gateway Program (1992), the Arona Campus (now Arona Academy) (1995), YES (Youth Education Sobriety) (1997, now closed), ExCEL Sober School (1998, now closed), and the

Aateshing Program (1998). Early programs outside Minnesota included Unity High School in Phoenix, AZ (1992, now closed), Recovery High School in Albuquerque, NM (1992, now closed), Phoenix Academy in San Mateo, CA (1992), Thoreau High School in Woodland Hills, CA (1996), Oasis Academy (now Community High School) in Nashville, TN (1997), Santa Rosa (CA) Clean & Sober High School (1998), and the Summit School in Spokane, WA (1998, now closed).

School founders included recovering persons who understood the need for school-based continuing care services, treatment professionals who had the training and foresight to create innovative schools; parents of recovering students who desired options for their children; and philanthropists and volunteers who were called to this new arena of community service. Some of early recovery high school pioneers included Ralph Neiditch, Carol Robson, and Konrad Friedemann (Ecole Nouvelle/Sobriety High), Barb Schmidt (PEASE Academy), Paul Grehl (Gateway), Rob van Kampen (YES), Mark Kuleta (Aateshing), Nichole Baum (ExCEL), LuAnn Woeltge (Arona), Judy Ide (Nashville Oasis Academy/Community High School), Nancy Tumosa (Phoenix Unity), Lou Sadler and Jan Hayes (Albuquerque Recovery High School). Lyle Taipale, with Sobriety High since 2003, helped establish two schools (Gateway and Arona) as a supervisor of alternative education in the St. Paul and Moundsview, MN, school districts.

In some cases, these pioneers helped conceive the idea and open the doors, and other leaders stepped in to keep the schools running and forge paths for other schools. Judi Hanson, Denise Martineau, and Jim Czarniecki helped Sobriety High expand to three campuses, and their assistance helped establish numerous recovery schools around the country. Similarly, Brad Kraushaar (Arona), Kellie Winter and Steve Massey (PEASE), Deb Seveland (ExCEL), and Ann Tash (Thoreau High School) helped their schools take root and set the stage for a rapid expansion of schools over the last few years. To date, the longest serving faculty member of any recovery school is Sobriety High's lead teacher, Larry Schmidt (1993-present). Schmidt, an English teacher, has developed curriculum designed specifically with the recovering teen in mind that he has shared with other schools and the professional treatment community.

The growth of recovery schools has been dramatic, with 25 recovery high schools and six collegiate recovery communities opening across the United States from 1999 to 2005. The recovery school movement was influenced by several important contexts: school choice policies, growth in alternative schools, the therapeutic community movement (of which recovery schools became an extension), the growth in adolescent chemical dependency programs (the first opening in Minnesota in the 1970s), and the growing recognition of the vulnerability for relapse for young people re-entering school following treatment. The inception of recovery high schools, also known as "sober schools", "dry highs", and "sobriety high schools", coincided with the adoption of school choice reform models in education policy. The idea that providing families with options within and outside the public sector would strengthen school accountability gave rise to legislation promoting alternative and charter schools, vouchers, and for-profit education companies. Minnesota and California were two of the first states to embrace school alternatives like charter schools and open enrollment policies, and notably, these were the first two states to open recovery high schools. This rapid recovery school growth spawned the Association of Recovery Schools, founded in 2002.

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The Coming Leadership Exodus: Leadership Development, Succession Planning and Graceful Disengagement

William L. White and Russell Hagen
Chestnut Health Systems

A generational passing of historic import has begun in the field of addiction treatment. The mass exodus of long-tenured leaders in public policy, private philanthropy, administration and management, clinical supervision, clinical services delivery, research and education/training has begun and will peak in the next five to seven years. This exodus raises the question of how long-tenured leaders can disengage in ways that enhance the health of multiple parties: themselves, their families, their organizations, their communities and the larger field of addiction treatment. This article offers ten suggestions on how to plan and execute such disengagement.

Time Your Exit There are two common pitfalls surrounding the timing of leadership disengagement. The first pitfall is that of premature disengagement. This occurs when a leader physically and emotionally disengages from the workplace before officially retiring, leaving his or her organization without effective leadership. A variation of this pitfall occurs when a leader leaves on short notice or is forced out precipitously without developing resources to fill the vacuum created by his or her sudden exit.

The second pitfall occurs when a leader remains too long. There is a delicate balance in the relationship between a leader and his or her organization, the communities served by that organization, and the larger field. These relationships evolve dynamically over time and can reach a point where the creative energy that has sustained them has been exhausted. The timing of a leader's exit from an organization and field should occur BEFORE that creative energy is exhausted.

But how do we know when that time has arrived? Consulting with one's family, friends and trusted colleagues can help sort out such timing issues, but, in the end, each leader must assess his or her own passion and performance to identify that time of transition. Affirmative answers to the following questions are important indicators of a need to renew one's leadership role or plan one's disengagement:

- Am I increasingly bored with my professional activities, drowning in a sea of organizational details that

have long ago lost their personal meaning to me?

- Do I feel I am no longer making a significant contribution to my organization and the field?
- Do I feel myself emotionally disengaging from my board, my managers, my staff and outside professional responsibilities?
- Am I spending more time as a leader looking backwards than forward?
- Am I concerned that my diminishment of physical energy or intellectual/interpersonal functioning is hurting my organization?
- Are there individuals inside or outside my organization who could provide better leadership than I am currently providing?

One of the most important things a leader can do is control the circumstances surrounding their own disengagement from active leadership.

Deal with Leadership Transitions Openly Leadership transitions are best processed at all levels of the organization by visibly acknowledging that: 1) leadership transitions will be occurring in the future, 2) the organization will intentionally manage these transitions through the development and recruitment of new leaders, and that 3) this is a time for aspiring leaders to prepare themselves for future leadership roles. The goal of such communications is to assure key constituents that there will be leadership continuity within the organization. This preparatory stage involves acknowledging and celebrating leaders throughout the organization, consciously and visibly anointing emerging leaders and disentangling the persona of the tenured leader from the organization. The latter is achieved by conveying that the strength of the organization is broad-based and does not reside within a single person.

Define Leadership Transitions in Terms of Opportunity Leadership disengagement can constitute an opportunity as well as a crisis. Such transitions provide opportunities for professional advancement and organizational renewal. There may, for example, be opportunities for acquisitions or mergers that should be considered at this time. Many organizations have not considered mergers or acquisitions out of loyalty to their long-serving leader. The major obstacle to such possibilities is often the question of what to do with two CEOs. When a leader leaves an organization, it opens the door to explore mergers or acquisitions that would not otherwise be considered.

Leadership transitions are also a time to realistically assess the strengths and weaknesses of the exiting leader and what those characteristics have meant to the life of the organization. All leaders have areas of competence and interest that get imbedded into the character of the organization. Leadership transitions are times that any imbalances can be identified and considered in the selection of new leadership. It is at such times that the board can assess the internal strengths and vulnerabilities of the organization and identify those leadership assets that are most important to the future of the organization.

The greatest opportunities in the next decade will accrue to line staff, line mangers and upper managers who have had little opportunity for upward mobility due to the low turnover in the managerial ranks. In the current exodus of leadership in the field, most organizations are not losing a single leader but a cadre of leaders. Replacing these leaders will create a ripple of opportunity within organizations and the larger field. It is important that younger members of the field are aware of this coming wave of opportunities and prepare themselves for greater professional responsibilities.

Develop an Exit Strategy: Permissions, Procedures and Processes to Guide the Disengagement Process The separation of leaders from their organizations is not unlike the process of terminating a service relationship between a therapist or therapeutic team and a client. This process can be actively managed by acknowledging the future disengagement of the leader, by providing the leader permission to disengage, and by creating rituals that facilitate loosening the bonds between the leader and the organization.

These healthy permissions, procedures and processes provide an antidote to more toxic processes that sometimes accompany career disengagement. The latter include agency boards' angrily scapegoating and prematurely extruding a longtime leader, leaders precipitously disengaging, and leaders setting their replacements up for failure (e.g., withholding critical information, inciting staff antagonism toward the new leader). Leaders who do not prepare themselves emotionally for this end stage are prone to prolong the disengagement process by retiring and then returning--again and again. Where a founder/leader has long been at the center of the emotional life of the organization, an outside consultant may be helpful in planning, facilitating and evaluating the disengagement and leadership transfer process.

Create Leadership Development and Succession Plans (and Create Them Early) The leadership development plan assures development of a cadre of leaders capable of assuming the leadership reins of the organization. Such plans outline strategies to identify aspiring leaders and to develop these leaders through further academic training, internal or external leadership development institutes and mentorship opportunities. Leadership development requires time and resources, making it important to develop and implement such plans long before key leaders leave their full-time positions. Like a number of organizations, Chestnut Health Systems (CHS) has a large core of its long-tenured executive, managerial and clinical leaders who will retire within a rapidly approaching five-year window. To help fill this void, we utilize a 70-member leadership council (that meets quarterly for training, teambuilding and leadership development) and are developing a new supervisory training program and a leadership development institute for aspiring leaders within the organization.

Where the leadership development plan focuses on the development of new leadership, a leadership succession plan structures the process through which current leaders will disengage from the organization and transfer their responsibilities to others. This plan should be jointly developed by the CEO, his or her executive staff and the executive committee of the board. The duties of the latter are to insist on leadership development and succession planning and to monitor the implementation of these plans.

Succession planning at CHS involves two distinct scenarios. The first is a plan for the orderly transfer of responsibilities in response to the temporary incapacitation of the CEO. The second is the interim transfer of responsibilities in response to retirement or a more sustained or permanent incapacitation or death of the CEO. CHS utilizes an Executive Leadership Council as its central management structure and the ten members of this council are also charged with the responsibility of developing leadership succession plans that cover these same eventualities for their organizational units.

Develop Leaders at All Levels and in All Positions At CHS, our initial concern with leadership development focused on the coming retirement of our core group of senior administrative and clinical leaders. As we began to address this concern, we developed a broader vision of developing leadership at all levels of the organization. Fulfilling this vision of distributed leadership is leading us to screen all new job applicants for leadership qualities, evaluate leadership as a dimension of performance evaluations, reward leadership as a desired quality in all

CHS staff and develop new internal and external staff development resources.

As we help our organizations develop and recruit the next generation of leaders, it is important to free ourselves from our own histories and to see the needs of our organizations and the field with fresh eyes. Most of the current generation of leaders entered their roles well trenched in the culture and values of addiction treatment, but spent most of their careers acquiring the managerial and technical skills to lead their organizations. In this system, the career path was often one of counselor, supervisor, unit director, clinical director and executive director / CEO. As these organizations have grown in size and complexity and as the operating environments of these organizations have become more demanding, replicating that style of leadership preparation may not be desirable or even possible. It is likely that the next generation of top leaders will need to bring great managerial and technical skills and will need to learn the culture and values of addiction treatment as they enter and serve the field.

Solidify Your Legacy Over the course of our careers, each of us has experienced hope that we might leave some lasting legacy to our organization and the larger field. As the end of our careers approaches, it is a good time to review the nature of that legacy and focus on bringing to fruition our final contributions. For some, that legacy will be a stable, financially solvent, high quality service organization. For others, it will be a well-trained clinical team, the organization of some new service initiative, procurement of funds for a special project, the mentoring of one's replacement or passing along one's knowledge in some durable form (e.g., a book or training video). Reflections on one's legacy can help focus the leader's final years and months and fill this time with renewed energy and meaning. Such reflections can identify precisely how we can best use our remaining time in our organization.

Generating renewed purpose at the end of a career can help solidify one's overall career satisfaction and enhance the sense of "leaving while on top." Many of today's aging leaders entered their careers during the frontier days of transitioning addiction treatment from a social movement to a legitimate professional field. Some will find great satisfaction in moving back to the frontier boundaries of the field during the last stage of their career, e.g., looking for new areas of service innovation or broader business opportunities that will help maintain the organization's core mission. The goal is to find a zone of activity in which one can be as energized at the end of one's career as one was at the beginning of that career.

Pass It On (It's Time for Focused Mentoring) The accomplishments that have marked our careers have been more than a product of our own intelligence, skill and effort. Luck of circumstance and the guidance of others contributed to these achievements. Particularly important were individuals who believed in us, mentored us and opened doors of opportunity for us along the way. One way of expressing our gratitude for such assistance is to pass that encouragement and opportunity on to the next generation of leaders in addiction treatment. Courtenay Baylor, a lay alcoholism psychotherapist at the Emmanuel Clinic in Boston in 1913, initiated the tradition of intergenerational mentoring among the lay psychotherapists (the first paid addiction counselors). Baylor taught other lay therapists that their helping careers were not complete until they had recruited and training their replacements. This master-apprentice tradition is still worthy of emulation.

We recommend that departing leaders increase the time they spend teaching, mentoring, modeling core organizational values and conveying the oral history of the organization and the larger field to the coming generations of addiction professionals. Each of us must ask ourselves what distinguishes addiction treatment from all other arenas of health and human service, and try to convey this historical essence to those who have no memories of a world without specialized

addiction treatment. We need to help the leaders coming behind us separate those issues that can be decided by expedience and consensus from those that must be decided by conviction. We have much to pass on, but those core values, core ideas, core service technologies and core management strategies may be our most important legacy.

Arrange a Proper Goodbye Most leaders and their boards have invested considerable time in financial preparations for the leader's retirement, but have invested much less time in preparing for the emotional processes involved in such transitions. Many leaders are uncomfortable with the emotional aspects of disengagement and sometimes prefer to avoid the discomfort of rituals like the retirement party. Leaders need to recognize that such rituals have as much to do with the health of the organization than with honoring their contributions. It is the exiting leader's responsibility to participate in rituals that facilitate leadership transition—a symbolic passing of the torch. These rituals serve numerous functions, from providing a venue in which everyone can expiate ambivalence about the leader's exit to providing a framework through which the leader can make necessary amends and express gratitude to key members of the organization and the community. Most importantly, this is a ritual to celebrate the accomplishments and continuity of the organization.

Get Out of the Way (Find New Pathways of Service) It is a rare leader who is not tempted to re-engage with the organization (via contact with staff and board members) following their exit. One must avoid the temptation to sabotage new leadership and to avoid being pulled into this role by others. One must avoid the tendency to become a ghost that continues to haunt the organization through hidden communications. Laying the foundation for the success of one's replacement and supporting the new leader is the final assertion of one's organizational commitment and professional competence. The final act of leadership is to get out of the way.

Every generation of leaders perceives their generation as special and approaches the end of their careers with trepidations about how the field will fare without them. But the historical truth is that new leaders will emerge from predictable and unlikely places and the work will go on. We must trust the momentum of such history and the efforts we have expended to nurture future leaders. It is time we stepped out of the limelight of leadership and found less visible but perhaps equally fulfilling ways to continue to serve our communities and our chosen field.

The future of the field of addiction treatment hinges on how well we perform this job of leadership development and transitioning. We have contributed and endured. The time is rapidly approaching for us to assume our rightful place as elders of this most unusual profession.

Acknowledgment: Support for this work was provided by the Great Lakes Addiction Technology Transfer Center (GLATTC) funded by the Center for Substance Abuse Treatment (CSAT). The opinions expressed here are those of the authors and do not represent the opinions or policies of GLATTC or CSAT.

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Citation: White, W. (2007) Before NAADAC: The pre-professional history of addiction counseling. *Addiction Professional*, 5(4), 30-33. Posted at **www.williamwhitepapers.com**

Before NAADAC:
The Pre-professional History of Addiction Counseling

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As NAADAC celebrates its 35th anniversary as an organization, it is a fitting time to look back over the history of addiction counseling. There is a growing body of literature on the history of addiction treatment, but the history of NAADAC and a definitive history of addiction counseling as a profession have yet to be written. This article will offer a few snippets related to the origin of addiction counseling and discuss the state of the field at the time NAADAC came into being. This article is a way to honor generations of men and women who spent their lives laying the foundation for what would become the profession of addiction counseling. We can still draw upon their lives and their stories for wisdom and inspiration.

Before There Were Addiction Counselors

There was no formal role of addiction counselor in the eighteenth and nineteenth centuries, but there were those who reached out to those with alcohol and other drug problems through activities that would later be integrated into this role. Those activities could be found in two settings: the earliest addiction recovery mutual aid societies and within America's first inebriate homes, inebriate asylums, private addiction cure institutes and faith-based recovery ministries.

Early addiction recovery support groups included Native American recovery circles, the Washingtonians, recovery-based fraternal temperance societies, the Ribbon Reform Clubs, the Drunkard's Club and the United Order of Ex-Boozers (Coyhis & White, 2006; Ferris, 1878; White, 1998). The reformed drunkard turned temperance missionary became a prominent figure in the American temperance movement. Individuals such as John Gough and John Hawkins used their charismatic speeches detailing their fall and redemption to call others into recovery (Gough, 1870; Hawkins, 1859). They also provided personal consultations with alcoholics and their families, helped organize local recovery support groups, and maintained a prolific correspondence with individuals and families in recovery.

The therapeutic branch of the American temperance movement became involved in "rescue work" with confirmed drunkards, and these efforts spawned calls for specialized treatment institutions. What followed in the mid-nineteenth century was an ever-expanding network of inebriate homes, medically-directed

inebriate asylums, private for-profit addiction cure institutes and urban rescue missions catering to late stage alcoholics. As "reformed men" sought service roles in these institutions, controversies raged about who was best equipped to do this work. The relapse of some prominent recovering temperance lecturers added to this debate (Benson, 1879; Berry, 1871). Dr. T.D. Crothers, a prominent leader in the American Association for the Study and Cure of Inebriety—the first professional association of addiction treatment providers--adamantly opposed the hiring of persons in recovery.

> *Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic deficits of the higher mentality....The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the work any length of time* (Crothers, 1897).

This debate died in the larger collapse of addiction treatment in the opening decades of the twentieth century—a collapse resulting from a perfect storm of intrafield factors (e.g., ideological schisms within the field, ethical abuses, aging leadership) and contextual factors (economic depressions, lost cultural faith in the prospects of long-term addiction recovery, and the advent of national alcohol and drug prohibition laws). In spite of the collapse of addiction treatment as a field, key functions performed by those in recovery carried into the twentieth century: self-disclosing, educating (including providing lectures during residential treatment), advising, encouraging, modeling, and linking individuals to sources of long-term sober fellowship. These functions mark a thread of historical continuity that influenced the later rise of addiction counseling.

The Lay Therapy Movement

Between 1900 and 1920, local efforts to treat alcoholism continued in spite of the larger national collapse of addiction treatment as a field. In 1906, the Emmanuel Church of Boston established a clinic that integrated religion, psychology, and medicine in the treatment of alcoholism. The clinic provided medical evaluation, educational classes, individual and group counseling, mutual support (the Jacoby Club), and personal support of Afriendly visitors@ (recovered alcoholics). Within a few years, the latter evolved into a formal system of *lay therapy*. Selected patients who had been successfully treated at the Emmanuel Clinic were trained to provide the same type of counseling they had received (Anderson, 1944).

Courtenay Baylor was hired as a lay therapist at the Emmanuel Clinic in 1913 following his own treatment there by Dr. Elwood Worcester. Baylor was the first person without traditional medical or psychological training to be employed full-time as a therapist specializing in the treatment of addiction. He was followed by other noted lay therapists, including Richard Peabody, Francis Chambers, William Wister, Samuel Crocker, Wilson McKay, and James Bellamy. Francis Chambers worked with noted psychiatrist Edward Strecker and is the first lay alcoholism therapist to work as a fully accepted member of the multidisciplinary teem within a major psychiatric hospital (Strecker & Chambers, 1938).

The essential approach of the lay therapists included negotiating a treatment goal of lifelong abstinence, eliciting a commitment for 60-100 hours of outpatient therapy, negotiating a contract for mutual confidentiality, sharing the therapist's personal addiction/recovery story, eliciting the client's story, analyzing the inciting causes of the client's alcoholism, educating the client about alcoholism, giving the client reading assignments, creating a daily schedule for each client, training the client in relaxation techniques, utilizing hypnotic suggestion, and teaching each client positive self-talk (McCarthy, 1984). Baylor's *Remaking a Man* (1919) and Peabody's *The Common Sense of Drinking* (1933) stand as the first texts devoted to the structure and techniques of alcoholism counseling.

The lay therapy movement exerted great influence on the re-emergence of alcoholism

treatment, but these therapists worked in isolation, maintained only informal contact with one another, and did not constitute an organized field of addiction counseling. The isolation within which they worked may have contributed to the relapse of some prominent lay therapists. If there is a single person who forms a human bridge between the early lay therapy movement and the rise of new outpatient alcoholism counseling clinics in the 1940s, it would be Ray McCarthy who pioneered many alcoholism counseling techniques at the clinics established by the Yale Center of Alcohol Studies in the 1940s.

AA and the Alcoholism Counselor

Alcoholics Anonymous experienced explosive growth in the early 1940s, and this growth and the efforts of the newly created National Committee for Education on Alcoholism (Precursor to today's NCADD) spawned a parallel growth in alcoholism treatment facilities. AA members, continuing a long "wounded healer" tradition, began working in various service roles within new alcoholism units in community hospitals (e.g., St. Thomas Hospital in Akron, Knickerbocker Hospital in New York), alcoholism units in psychiatric hospitals (e.g., Rockland State Hospital, Manteno State Hospital), alcoholic Aretreats@ and "farms" (e.g., High Watch, Alina Lodge), and in new facilities operated by members of A.A. clubhouses, (e.g., Twelfth Step House in New York, Friendly House in Los Angeles). What emerged were guidelines that helped AA members clearly delineate their A.A. activities from their paid activities as nurses, social workers, psychologists, and lay therapists.

The road from lay therapy to modern addiction counseling wound through the state of Minnesota in the late 1940s and 1950s. It was there that three abstinence-based, AA-oriented alcoholism programs—Pioneer House, Hazelden and Willmar State Hospital—birthed what came to be called the Minnesota Model of chemical dependency treatment. For purposes of our discussion this model had two very important influences. First, it birthed the role of the alcoholism counselor at the center of a multidisciplinary alcoholism treatment team—even getting the State of Minnesota Civil Service Commission to establish the civil service position of "Counselor on Alcoholism" in 1954. (The position required two years of sobriety and a high school education.) Second, the model was widely replicated across the United States. That replication sparked the rise of the new specialty role of alcoholism counselor in communities across the country (White, 1998).

That therapy for the alcoholic would be relegated to the lay alcoholism psychotherapist was not without its challenges. Alcoholics regularly found themselves in services setting with physicians, nurses, psychologists, social workers and pastoral counselors and many of these traditional service professions were employed to work in specialized alcoholism treatment setting. A central debate of the 1960s was, "Who is qualified to treat the alcoholic?" (Krystal & Moore,1963).

The Ex-Addict Counselor

In 1958 Charles Dederich founded Synanon—the first ex-addict directed therapeutic community (TC) for the treatment of drug addiction. Six years later, Drs. Marie Nyswander and Vincent Dole introduced methadone maintenance treatment (MMT) in the United States. As TC's and MMT spread in communities across the U.S., the "drug abuse counselor" role emerged as a central service role within each modality. The polydrug epidemic of the 1960s generated new mainstream and countercultural service institutions (e.g., free clinics, crisis lines, drop-in centers, "acid rescue"). Many of these institutions morphed into "outpatient drug free" counseling clinics in the 1960s and early 1970s. The primary service role within these clinics was also that of the drug abuse counselor. Added across these setting was a mix of traditionally trained nurses, psychologists, social workers and clergy drawn to service with this particular client population and the frontier nature of the field, or drawn to the field to work out their own troublesome relationships with alcohol and other drugs.

The first national meetings that brought what were then christened "para-professional counselors" together from these diverse service settings were something to behold. Meetings

were loud and boisterous as treatment philosophies (more like religions then) and personal values and lifestyles collided. Such differences were further amplified in the first meetings that brought the alcoholism treatment workforce together with the drug abuse treatment workforce. That a professional field emerged from these building blocks is something of a miracle—a miracle of leadership in which NAADAC played a significant role.

Closing Reflection

As we celebrate this historical milestone for NAADAC, we should pause to consider the state of the field when NAADAC was founded. In 1972, the federal, state and local partnership that has been the hallmark of modern addiction treatment was just being formed with no promise that it could sustain itself. The field at all levels was really two fields—an *alcoholism field* and a *drug abuse field*—fields that viewed each other with mutual hostility and distrust. It took more than a decade and much heated debate to forge an integrated field of addiction treatment that could distinguish itself from the broader arenas of health and human services. In 1972, few treatment programs rested on a solid financial infrastructure. Programs lived from single grant to single grant, staff were paid a pittance, and at the end of each funding year, counselors often left work on a Friday not knowing if their organization or their jobs would exist on the following Monday. In 1972, there was no defined core of knowledge and skills for addiction counseling, no formal addiction counselor training programs nor any advanced degrees in addiction studies. There were no national established standards of practice for programs or individual practitioners. There were no universally accepted code of ethical conduct in the practice of addiction counseling and not a single book available on that subject.

In 1972, the field utilized a predominately recovering workforce whose members brought little if any formal training prior to their entry into the field, and yet few guidelines existed on the screening, hiring, orientation, training and on-going supervision of these early addiction counselors. The field's workforce was dominated by white men, and it took more than twenty years to significantly increase the numbers of women and people of color working as addiction counselors. That we have come so far in my professional life span is itself a tribute to NAADAC's sustained presence as a force of influence within the larger field of addiction treatment.

Happy Birthday NAADAC. You nurtured the field of addiction counseling through a turbulent birth and adolescence. You lit our pathway from par-professional to professional status. You have been there to guide us into maturity. Some would say we are now facing a mid-life crisis in which we need to redefine the very essence of who and what we are as a profession. The threats to, and opportunities for, the profession of addiction counseling have never been greater. Today, we need NAADAC's leadership more than ever.

Acknowledgement: This article is dedicated to Mel Schulstad, NAADAC pioneer and devoted mentor and friend, who taught me the heart of addiction counseling.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2007) Can recovering drug addicts drink? A historical footnote. *Counselor*, 8(6), 36-41. Posted at **www.williamwhitepapers.com**

Can Recovering Drug Addicts Drink? A Historical Footnote

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In 2006, the author wrote an essay entitled "Alcohol, Tobacco and Other Drug Use by Addiction Professionals: Historical Reflections and Suggested Guidelines" that was widely circulated within the addictions field). The essay briefly noted a period in the history of therapeutic communities when clients (mostly recovering heroin addicts) could earn "drinking privileges" during the later stages of their treatment. The number of resulting emails regarding this practice and their pointed questions and animated comments suggested the need to elaborate on this fascinating chapter in the history of treatment. The twin purposes of this article are to recount the evolving policies toward alcohol within therapeutic communities and to offer reflections on the lessons that can be extracted from this interesting footnote in the history of addiction treatment and recovery in America.

Alcohol and the Early Therapeutic Community

Most readers of *Counselor* know the highlights of the history of therapeutic communities (TC) for the treatment of addiction. The TC movement began with the founding of Synanon in 1958, extended itself into the second generation therapeutic communities of the 1960s and 1970s, and was subsequently professionalized and modified for many institutional settings and special populations (DeLeon, 1984; White, 1998). Today, TCs constitute a primary and rigorously evaluated modality of addiction treatment that has exerted considerable influence on the larger arena of addiction treatment throughout the world (DeLeon, 2000).

The early policy of alcohol abstinence within Synanon was influenced by the history of its charismatic founder, Chuck Dederich. Dederich had used Alcoholics Anonymous (AA) to initiate his recovery from alcohol and Benzedrine addiction in the two years that preceded his split from AA and the creation of Synanon. Synanon maintained an alcohol abstinence policy until 1978, at which time alcohol was experimentally introduced first for board members and senior staff and then to others within the Synanon community. Alcohol problems grew within Synanon in the 1980s and contributed to Charles Dederich's fall from grace and Synanon's eventual

implosion as an organization (Mitchell, Mitchell, & Ofshe, 1980; Janzen, 2001).

The second generation TCs of the 1960s and early 1970s (e.g., Tuum Est, Amity, Daytop Village, Gateway, Phoenix House, Gaudenzia, Archway House, to name just a few) varied in their alcohol policies depending on when they were founded. Most emulated Synanon's early alcohol abstinence policy during their first years of operation, but as with Synanon, this changed over time. Part of the reason for this shift was the absence at that time of a well-articulated rationale for why a former heroin addict should abstain from alcohol.

During the 1960s and much of the 1970s, there was an "alcoholism field" and a "drug abuse" field—each operating in virtual isolation from one another. There were local drug programs and local alcoholism programs, with only a few brave programs experimenting with what was first called "combined treatment" (of alcoholics and addicts). TCs and Twelve Step programs constituted separate worlds, with TCs believing that they were different from and superior to anything that had come before. Within the larger fields, there were separate national institutes (that still remain), separate state agencies, separate professional associations, separate counselor training programs, separate counselor credentialing bodies, and separate local community advocacy groups—all split along the alcohol and drugs demarcation. Most importantly, there was no universally accepted concept of "addiction" or "chemical dependency" that provided a bridge in linking alcoholism to addiction to opiates and other traditionally defined "drugs". It is only in the context of such separation that the continuing history is understandable.

From Abstinence to Drinking Privileges

The first change in alcohol policies within American TCs occurred in Daytop in New York City. In 1965, a party was held to celebrate members who had been drug free in Daytop for 1-2 years. Drinking was permitted at this celebration, and the event was completed without any incidents of intoxication. In late 1966 and early 1967, the option of social drinking in certain circumstances was formally discussed in management meetings at Daytop. It was decided that social drinking (defined as drinking 1-2 drinks of alcohol in a social situation in the presence of more senior members of the community) would be permitted as an earned privilege for those approaching community reentry and by others (staff and graduates) in good standing within Daytop. At the "confirmation" signaling the end of phase one treatment, the client was taken out to dinner by senior TC staff. The client was expected to drink wine at dinner as a token of congratulations on his or her progress in treatment. The goal was also to provide a model for moderate drinking as part of one's community reentry experience.

Several things are noteworthy related to this practice. First, this was introduced into a community of recovering heroin addicts, many of whom had no prior history of drinking except to medicate the sickness of heroin withdrawal. Second, those with alcohol problems that preceded or co-existed with heroin addiction were given a clear message to avoid drinking. It was assumed by TC leaders at this time that the percentage of TC members vulnerable for alcoholism was about what it would be in the general population—estimated at that time to be about 6-10%. Third, this policy change did not constitute permission for intoxication. Intoxication was confronted and, if repeated, resulted in a loss of status in the TC. Fourth, problems related to this change in policy were not immediately evident (the supportive cocoon of the TC "family" may have prevented or slowed development of such problems). As a result, this relaxed policy on alcohol was transmitted to a large number of other second generation TCs through the influence of Daytop and then from second to third generation TCs. This evolution in TC alcohol policies unfolded within the larger drug treatment field (non-TC programs) that excluded alcohol from its stated goal of post-treatment abstinence.

The first signs of problems with the alcohol policy within Daytop and other TCs

followed a predictable two-stage pattern. The first stage was the appearance of drinking at social events within the TC community (e.g., staff parties) and at outside professional conferences that exceeded the bounds of social drinking and sparked other inappropriate behaviors. The second was the development of severe alcohol problems (or relapse back to heroin and other drugs while under the influence of alcohol) among some TC staff and graduates. The development of alcohol problems among those who left the TC for the community was not evident early on but became more visible over time and as follow-up became more routine and rigorous.

The alcohol-related problems of TC staff were significant enough that some TCs developed formal relationships with alcoholism treatment programs to which they could refer staff for treatment. In spite of these early alcohol-related casualties, the relaxed policies toward alcohol and the practice of "drinking privileges" continued in many TCs well into the early 1980s. A factor that slowed the recognition of the problem of alcohol was the presence of "ex-addicts" who were drinking socially and without any evident alcohol problems. These normal drinkers masked the reality of individuals who had significant leadership positions within various TCs who literally were drinking, and eventually drank, themselves to death. After alcohol policies changed, some staff who had resumed drinking under the earlier policies continued to drink in the following years. This created an uncontrolled experiment of social drinking among former heroin addicts whose outcome has never been formally investigated.

Changing Alcohol Policies

As alcohol problems were emerging in many TCs, one individual, Michael Darcy, and one TC, Gateway Foundation, took the lead in calling upon the larger TC movement to rethink its policies on alcohol. Gateway is a second-generation TC (founded in 1968) that was heavily influenced by Daytop. Gateway emulated Daytop's drinking policy, but began to reevaluate that policy after eight of its first ten staff members developed alcohol problems after successfully recovering from addiction to heroin and other drugs. Gateway changed its alcohol policies through several steps over the course of 1973-1974. It began by introducing an alcohol abstinence philosophy and negotiating a formal arrangement with the Grant Hospital Alcoholism Treatment Unit to treat any Gateway staff experiencing alcohol-related problems. It then contracted with the Lutheran General Alcoholism Program to provide system-wide training within Gateway on alcoholism and its treatment, and began integrating Twelve Step philosophy into its existing TC philosophy.

There was considerable resistance early on within Gateway and the larger TC movement to the alcohol policy change. Early adoption of this policy change in other TCs began in the late 1970s and early 1980s and then spread slowly to most TCs by the mid-1990s. Several things helped consolidate this shift in TC philosophy. There was the pioneering work of early TCs that integrated the treatment of opiate addicts and alcoholics (Eagleville Hospital and the influence of Dr. Don Ottenberg is particularly noteworthy here). There was the eventual merger of the alcoholism and drug abuse fields and local alcoholism and addiction treatment programs. There was growing scientific evidence on the phenomenon of cross-addiction, including early studies noting alcohol problems among TC graduates in the US and Europe (Ogborne & Mellote, 1977).

Reflections

So what does one take from this interesting historical footnote? History promises us important lessons if we sit at her feet and listen carefully to her stories. Answers to some of the questions posed by this historical account will likely be revealed in the science laboratory, but there are findings of cumulative experience that have important clinical implications.

Addiction to one drug may be shared by, and may even increase one's

vulnerability for, addiction to other drugs. The roots of such broad-spectrum drug vulnerability and other excessive behaviors seem to be the engagement of a common neurological reward system. That broad spectrum of vulnerability should be a consistent message and warning to all individuals undergoing addiction treatment.

The prevalence of cross-addiction in the history of the TC is unknown. TC old-timer estimates of how many "ex-addicts" later got in trouble with alcohol range from the majority to less than 10%, but all of the TC elders interviewed for this article reported tragic stories of alcoholism-related deaths among early TC graduates.

Individuals recovering from drug dependencies (other than alcohol) who later develop problems with alcohol do so through a variety of patterns and across a continuum of severity and duration. The factors that differentially shape the trajectory and outcomes of such problems are unclear.

There are observed, but untested, predictors of those individuals recovering from drug dependence (other than alcohol) who are most likely to go on to develop the most severe and prolonged alcohol-related problems. When those with long histories within the TC movement are asked to recount such factors based on their observations over the past 40 years, they most often note the following risk factors: 1) a family history of alcohol problems, 2) a history of alcohol problems predating the emergence of another pattern of drug dependence, 3) co-addiction to alcohol and other drugs prior to entry into treatment, 4) the presence of a co-occurring psychiatric illness, 5) a history of childhood victimization, 6) later developmental trauma (e.g., loss via death or separation), and 7) enmeshment in a heavy drinking social network.

The dichotomy of "alcohol problems" and "drug problems" is breaking down as concurrent and sequential multiple drug use becomes the norm among persons entering addiction treatment. This trend is rendering clinically anachronistic such concepts as "drug choice".

In spite of the quite different drug cultures that surround the use of particular drugs, at a neurological level, these substances share more commonalities than differences (Nature Neuroscience, 2005). While that potentially explains the propensity for cross-addiction, it leaves unanswered the question of how some individuals are able to recover from lives devastated by heroin addiction and then maintain non-problematic drinking while others achieve recovery from heroin addiction only to have their lives devastated by alcohol. This complex finding is one of the legacies of the TC movement's experiment with drinking privileges. Perhaps many or most (a question the scientists need to answer for us) people entering addiction treatment possess a lifelong vulnerability for addiction to a broad spectrum of substances (and experiences), while in others that vulnerability is transient or restricted to a particular drug or class of drugs.

Until such questions can be answered scientifically, we have a clinical responsibility to share warnings related to the field's experience with this issue. At the same time, we have the responsibility to honestly acknowledge that there is much we do not know about these varied patterns of vulnerability and resilience. Lacking science, we need to offer explanatory models that help each client make personalized, informed choices related to the whole spectrum of psychoactive drug use.

Acknowledgement: I would like to thank the many TC pioneers who agreed to be interviewed for this article. Particular thanks for their willingness to discuss the evolution in policies toward alcohol use in American therapeutic communities go to Michael Darcy, President/CEO of Gateway Foundation, Inc.; David Deitch, Chief Clinical Director, Phoenix House Foundation; Charles Devlin (now retired), former Sr. Vice President of Treatment Services, Daytop; Michael Harle, President and Executive Director of Gaudenzia, Inc.; and John Ruocco (now retired), Founder of Gaudenzia and former Director of Reentry Programming, Phoenix House.

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Citation: White, W. & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, 8(4), 12-30. Posted at **www.williamwhitepapers.com**

The Use of Confrontation in Addiction Treatment History, Science, and Time for Change

William L. White, MA, and William R. Miller, PhD

Abstract

The use of confrontational strategies in individual, group and family substance abuse counseling emerged through a confluence of cultural factors in U.S. history, pre-dating the development of methods for reliably evaluating the effects of such treatment. Originally practiced within voluntary peer-based communities, confrontational approaches soon extended to authority-based professional relationships where the potential for abuse and harm greatly increased. Four decades of research have failed to yield a single clinical trial showing efficacy of confrontational counseling, whereas a number have documented harmful effects, particularly for more vulnerable populations. There are now numerous evidence-based alternatives to confrontational counseling, and clinical studies show that more effective substance abuse counselors are those who practice with an empathic, supportive style. It is time to accept that the harsh confrontational practices of the past are generally ineffective, potentially harmful, and professionally inappropriate.

Treatment for substance use disorders in the United States took a peculiar turn in the mid-20th century. There arose a widespread belief that addiction treatment required the use of fairly aggressive confrontational strategies to break down pernicious defense mechanisms that were presumed to accompany substance use disorders. Although this approach was emulated to some extent in certain treatment centers outside the United States, such reliance on confrontation was predominantly an American phenomenon. As discussed below, there was some broader exploration of confrontational therapies, but nowhere did they take such deep root as in U.S. addiction treatment. Indeed, few would now regard such harsh methods as therapeutic for any other Axis I disorder in *the Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994).

What accounts for this odd detour in American addiction treatment? In this article we trace the historical roots of belief in and practice of confrontational treatment, and explore relevant scientific evidence on the effects of such methods. We then offer summary conclusions and recommendations for treatment of substance use disorders in the 21st century.

A History of Confrontational Therapies

What Is Confrontation?

Therapeutic confrontation has been defined as the process by which a therapist provides direct, reality-oriented feedback to a client regarding the client's own thoughts, feelings or behavior (Forrest, 1982). Such communications may spring from compassion and concern, or from exasperation and contempt. They also vary in their intent, timing, intensity, emotional content, accompanying interventions, and the relationships and organizational contexts within which they occur (Polcin, 2003).

In the mid-twentieth century, addiction counselors developed and advocated a particular style of direct verbal confrontation of those with alcohol and other drug problems. These communications varied from frank feedback to profanity-laden indictments, screamed denunciations of character, challenges and ultimatums, intense argumentation, ridicule, and purposeful humiliation. Confrontation marked a dramatic break from earlier therapeutic traditions premised on the importance of neutral exploration, empathy, compassionate support, and positive regard for clients.

Many examples of allegedly therapeutic confrontation can be found in the addiction literature of the 1960s and 1970s. Two brief examples serve here as illustrations. The first is from the front page of the January 13, 1983 *Wall Street Journal*, describing a physician-led intervention with a corporate executive:

> They called a surprise meeting, surrounded him with colleagues critical of his work and threatened to fire him if he didn't seek help quickly. When the executive tried to deny that he had a drinking problem, the medical director . . . came down hard. "Shut up and listen," he said. "Alcoholics are liars, so we don't want to hear what you have to say" (Greenberger, 1983).

The second comes from Chuck Dederich, the founder of Synanon, counseling a Mexican-American addict in a therapeutic community, who balked at being ordered what to do:

> Now, Buster, I'm going to tell you what to do. And I'll show you. You either do it or you'll get the hell off Synanon property. You shave off the moustache, you attend groups, and you behave like a gentleman as long as you live here. You don't like it here? God bless you, I'll give you the same good wishes that I gave other people like you when they left and went off to jail. That's the way we operate in Synanon; you see, you're getting a little emotional surgery. If you don't like the surgery, fine, go and do what you have to. Maybe we'll get you again after you get out of the penitentiary or after you get a drug overdose. "Nobody tells me what to do!" Nobody in the world says that except dingbats like dope fiends, alcoholics, and brush-faced-covered El Gatos. (Yablonsky, 1989) p. 122).

Theoretical Foundation

Although treatment systems for alcoholism and for narcotic addiction constituted two separate professional domains during much of the twentieth century, both fields developed parallel theories that fostered confrontational approaches to therapy. Between the 1920s to 1950s, U.S. theories of narcotic addiction shifted from biological models of causation to models that posited the source of addiction as lying within the flawed character of the addict. Dr. Lawrence Kolb, a prominent psychiatrist and the first medical director of the Federal Narcotic Hospital in Lexington, Kentucky was an early figure in this shift of perspective. Kolb (1925) observed that the dominant profile of addiction had shifted from the "innocent" addict who had accidentally become drug dependent as a side effect of medical treatment, to the "vicious" addict

who sought narcotics as a source of excitement and pleasure. In Kolb's view, the latter type of addict had a defective, psychopathic personality with a prolonged history of social maladjustment and enmeshment in deviant criminal subcultures (Acker, 2002). This led initially to a view of treatment as requiring a period of quarantine with a structured program of institutional care that could enhance personal maturation and pro-social values. It was assumed that a drug-free social adjustment in the institution would then transfer to a similar style of adjustment in the community. The failure of this assumption, confirmed by reports of very high post-discharge relapse rates, created a climate of frustration that fostered a search for alternative treatments—alternatives that included confrontational therapies.

Dr. Harry Tiebout's psychoanalytic observations in the 1940s and 1950s on alcoholics and their recovery process set the stage for confrontational therapies in the treatment of alcoholism. Tiebout contended that alcoholism was rooted in character malformation that consisted of ego inflation (narcissism, grandiosity, dishonesty), self-encapsulation (disconnection from and suspiciousness of others), inner tension and hostility (guilt, anger, resentment), and a preoccupation with power and control (resistance to external influence, defiant individuality). The alcoholic in his view was incapable of accurate self-perception due to an elaborate system of defense mechanisms (e.g., denial, projection of blame) that simultaneously justified drinking and buttressed self-esteem. Tiebout believed that this defense structure became entrenched over the long course of alcoholism until the alcoholic hit bottom and experienced full surrender (conversion)—a disciplining process that produced deflation of the infantile ego, self-acceptance, humility and inner peace.

The task of the professional helper, according to Tiebout, was to move the alcoholic from superficial verbal compliance (and behavioral defiance) into and through a process of surrender, personality reconstruction and the development of a disciplined way of life (Acker, 2002; Tiebout, 1949, 1953, 1961; Tiebout et al., 1963) – an early source of the aphorism, "Break 'em down to build 'em up." Tiebout's influence was significant due to his close association with A.A., the widespread dissemination of his writings, and his prominence as a speaker at professional alcoholism conferences. He suggested that therapists could hasten the alcoholic's recovery process by puncturing narcissistic encapsulation, confronting faulty reasoning processes, inducing a surrender experience and facilitating reconstruction of personal identity and relationships.

Without the legitimizing theoretical foundation laid by Kolb, Tiebout, and others, the emergence of harsh confrontation techniques in the late 1950s and 1960s might have been viewed as countertransference run amok, and gross violation of professional ethics. Instead, it came to be viewed as a necessary approach to treatment, "the only language they can understand." Therapeutic confrontation was essentially founded on four inter-related assumptions (Bassin, 1975).

> 1) Addiction is rooted in an immature, defective character encased within an armor-plated defense structure. Indeed, in DSM-II, alcoholism and drug dependence were classified as personality disorders. Vernon Johnson (1973) opined that "the alcoholic evades or denies outright any need for help whenever he is approached. It must be remembered that he is not in touch with reality." (p. 44).
> 2) The seemingly passive methods of traditional psychotherapies are hopelessly ineffective in penetrating this defensive structure and altering deformity of character
> 3) The addict/alcoholic can therefore be reached only by a "dynamite charge" that breaks through this protective shield, and
> 4) Verbal confrontation is the most effective means of engaging and changing addictive behavior.

Following its introduction in addiction treatment, there was some short-lived exploration of broader uses of confrontational therapies in the United States "to separate what a man is from

what he seems to be, states himself to be, or would have us believe he is" (Weisman, 1973; p. 103).

Cultural Context

Trends in psychotherapy mirror evolving cultural temperaments (Forrest, 1982). Confrontational therapies were diffused into addiction treatment during a decade (the 1960s) rife with social confrontations and challenges to existing values and traditions. New therapy centers promised cathartic, life transforming experiences through vehicles such as psychodrama, Gestalt therapy, Erhard Seminars Training (EST), Primal Scream, regression therapies, and confrontation or attack therapies. Elements of these new therapies seeped into the larger cultural phenomenon of "sensitivity training." The National Training Laboratories in Bethel, Maine and the Esalen Institute in Big Sur, California, became centers for the dissemination of many of these therapeutic techniques and an incubation chamber for the larger "human potential movement." It is doubtful that confrontation therapies could have been so extolled and diffused so widely and rapidly in any period other than within the social turmoil and "free-for-all approach to psychotherapy" and personal growth of the 1960s and 1970s (Singer & Lalich, 1996; p. 113).

The theoretical premise of these cathartic therapies was that a wide spectrum of human suffering was rooted in repressed feelings and that such suffering could be alleviated through techniques that facilitated emotional release. The human being was pictured as a pressure cooker of repressed emotions that, if not released, manifested themselves in a plethora of physical, emotional and relationship problems. Great curative properties were attributed to the venting of emotions. Attack therapies, in this view, functioned to tear down the masks that contained repressed emotions, allowing the individual to get "real" with themselves and others. Confrontational tactics spread beyond therapeutic settings to such wider movements of the 1970s as encounter groups, Lifespring, Mind Dynamics, Insight Seminars and Erhard Seminars Training (EST) (Singer & Lalich, 1996). The broader adoption of confrontational techniques by allied professional fields and the larger community seemed to validate the addiction field's use of such techniques. Fritz Perls' use of the "hot seat" in Gestalt Therapy (Perls, 1969) and William Glaser's Reality Therapy (Glasser, 1965) were particularly influential in justifying the use of confrontation in addiction treatment.

Synanon and Therapeutic Communities

In January 1958, Charles Dederich, less than a year sober in Alcoholics Anonymous, began hosting a weekly discussion meeting for alcoholics in Ocean Park, California. In these "loud and boisterous" meetings, a freewheeling style of verbal confrontation emerged that was used to "let the air out of pompously inflated egos." The communication style within the meetings was an extension of Dederich's own loud, bombastic, gruff and profane style. By summer, the numbers of those attending these meetings had grown to the point that Dederich was forced to rent a clubhouse. A number of self-described "hope-to-die dope fiends" enmeshed themselves in the life of the clubhouse and got clean for the first time in years. When conflict between Dederich's growing legion of alcoholics and addicts and local AA groups reached a crisis in September 1958, Dederich and his followers left AA *en masse* and formed Synanon—the first ex-addict directed therapeutic community (Yablonsky, 1965).

Synanon became a self-supporting, peer-based recovery community. Within this community, pro-social behavior was rewarded with increased role responsibilities and status, and anti-social behavior was immediately and intensely confronted. The paucity of viable addiction treatment alternatives and the riveting redemption anecdotes of its members contributed to Synanon's early professional and cultural popularity. By the mid-1970s, more than 500 addiction treatment programs in the United States were modeled on Synanon, and more

than 2,000 non-addicts were paying to participate in Synanon's no-holds-barred groups (Deitch & Zweben, 1981).

Synanon's (and Dederich's) subsequent rise and fall over the following decades is beyond the scope of this article (see Janzen, 2001; Mitchell, Mitchell, & Ofshe, 1980), but Synanon's role in the history of confrontation in addiction treatment is a crucial one. Synanon's aggressive confrontation techniques were transmitted to second-generation therapeutic communities (TCs) such as Daytop, Phoenix, Gateway, Gaudenzia, The Family, and Walden House and were then widely diffused into the larger emerging treatment system in the 1970s. The thousands of professionals trained by Synanon and the immense popularity of Synanon's "game club" (Synanon-facilitated groups for non-addicts) spread confrontational techniques into broader schools of psychotherapy and into the larger human potential movement of the 1960s and 1970s (Deitch & Zweben, 1981).

Early therapeutic communities utilized many mechanisms of confrontation, including:

- *Motivational Litmus Tests at Admission:* Forced confession at the end of a confrontational intake interview that one was a baby, was stupid and needed help, and the surrendering of something of value to demonstrate one's commitment to recovery (e.g., money, property, one's hair).
- *Pull-ups:* Immediate feedback from one community member to another regarding inappropriate behavior.
- *Image work:* Demands to change physical appearance and demeanor (everything from how one talked to how one walked).
- *Haircut:* A group session in which a relatively new member is "taken apart" by community elders and given prescriptions for improving his or her attitudes and behavior.
- *Learning Experience:* An assignment intended as a form of self-confrontation and communication to other community members. Examples include being "busted" from a higher status position to the dishpan; wearing a diaper, a toilet seat, or a sign (e.g., "I'm a baby. Please help me grow up.") for a prescribed period of time; having one's head shaved.
- *The Synanon Game:* A no-holds-barred group therapy that utilized verbal attack and ridicule to strip the participant's exterior image and defenses while supposedly toughening them on the inside.
- *Probes, Reaches, Trips, Marathons & Stews*: Versions of the Synanon Game that could extend for prolonged periods of time (6-8 hours to days)
- *The Fireplace Ritual (General Meeting*): A meeting called of the whole community to confront a single individual's behavior (Gerstel, 1982; Olin, 1980; Yablonsky, 1965).

The centerpiece of the TC experience and the engine that fueled the TC community was the Game—a leaderless group experience that was a mix of verbal brawl, group confessional, confrontational theater, and improvisational comedy (White, 1998). Dederich described the Game as "a full unfettered expression of the most intimate and inner-most thoughts, feelings, fears, ambitions, obsessions, convictions, hatreds, prejudices, joys and hopes" (quoted in Olin, 1980, p. 162). The goals of the Game were to shed the "code of the streets," drop one's "dope fiend" image, honestly face oneself, and to dump your "emotional garbage" inside the Game so that you could be happy and act responsibly outside the Game (Gerstel, 1982, p. 17). The explicit lack of confidentiality related to anything disclosed during the Game added to its power. One's "jacket" (psychological profile) was broadly disseminated to all TC members with the expectation that feedback and support related to needed behavioral changes would be consistent in all of one's peer interactions. The gross effect was intended to be a form of psychological and behavioral surgery: the removal of unhealthy character defenses and behaviors and the implantation of healthier defenses and behaviors in their place (Yablonsky, 1965). The Game

was nested in a vibrant recovery community whose mutual support was as intense as the confrontations for which it was better known. A core of early TC "graduates" quickly moved into staff positions in the 1970s within the growing network of addiction treatment programs, and, in a process akin to intergenerational hazing, replicated use of these techniques with newly arriving clients throughout the United States and beyond.

Confrontation in the Minnesota Model[1]

In the late 1940s and early 1950s, a synergy between three alcoholism treatment programs—Pioneer House, Hazelden and Willmar State Hospital—birthed an approach to the treatment of chemical dependency that was widely replicated in the following decades. Confrontation was not a technique used within the original Minnesota Model, but was gradually introduced into that model in stages. The first stage was the emergence of the concept of "tough love"—a concept from Al-Anon that when interpreted within the treatment context argued that the alcoholic needed to be confronted directly about his or her behavior and held accountable for the consequences of that behavior. An important corollary was the concept of "enabling." This concept depicted well-intentioned attitudes and behaviors exhibited by those around the alcoholic that, by protecting the alcoholic from the consequences of his or her behavior, inadvertently sustained the alcoholic's drinking and related problems.

While the concepts of tough love and enabling eased the way for the introduction of confrontation techniques, it is surprising that group confrontation would emerge within a model of treatment so heavily influenced by A.A.. A.A. and the peer-based lay psychotherapy models that preceded it (Peabody, 1934) were distinctly non-confrontational, with A.A. even discouraging crosstalk at its meetings. In the A.A. meeting culture of the 1930s and 1940s, members did not provide direct feedback or advice to one another, but responded to any disclosure by sharing their own related experience. Confrontational therapies are clearly not rooted in the origins and core literature of A.A. (Miller & Kurtz, 1994).

Confrontational techniques emerged within Hazelden as staff sought new ways to engage and manage a subset of clients they perceived as having severe characterological problems. In the late 1960s Hazelden began treating younger opiate and polydrug addicts whose behaviors were harder to manage within the treatment milieu. Seeking solutions to this dilemma led Hazelden staff to visit Eagleville Hospital in Pennsylvania which was pioneering "combined treatment" (integrated treatment of alcoholics and addicts). Eagleville had emulated the confrontation techniques of Synanon, Daytop and other early TCs and became the conduit for introducing these techniques at Hazelden. Openness to such confrontation techniques at Hazelden came in part from working with addicts who were perceived as "sicker" and harder to reach.

In 1967, Hazelden started a "Repeaters' Program" and began using a peer evaluation ("hot seat") technique within the group therapy session on this unit. In this technique, a member of the group occupied a center chair within the group and his/her attitudes and behaviors were critiqued by other group members using an inventory sheet of 23 items, 22 of which were character defects; e.g., resentful, prideful. By the mid-1970s, the use of the "hot seat" technique had spread to all units at Hazelden and commonly included the use of derogatory language and labels. This technique was spread into the larger field by former Hazelden staff and the large numbers of people who received training at Hazelden.

In the late 1970s, the use of confrontation was re-evaluated at Hazelden. The use of the "hot seat" in the women's units was stopped when it came to be viewed as too harsh and disrespectful. The use of confrontation on the men's units also changed. A new inventory was integrated into the peer evaluation process that included character assets, and the person being

[1] This section is based on interviews conducted in September 2006 with Minnesota Model historian Damian McElrath and Gordon Grimm, Bruce Larson, Harold Swift, and Terry Williams.

evaluated was moved from a center chair to a chair within the group to reduce his or her vulnerability. To emphasize this change, the "hot seat" was re-christened the "love seat" and an emphasis was placed on the use of "compassionate confrontation." By 1985, Hazelden was already describing confrontational counseling as a thing of the past:

> There was a time when the dominant mode of chemical dependency treatment was based on a "tear 'em down to build 'em up" philosophy. . . Counseling sessions sounded disrespectful and dehumanizing. And they were. . . Patients don't need to be "put down" to deal with symptoms . . they need to be treated as individuals, with the same rights and respect we expect for ourselves. We're concerned because many treatment programs still use these confrontational techniques. Some even call themselves Hazelden or Minnesota models. It's true that we once used confrontation. But we found a better way. (Hazelden Foundation, 1985, p. 2).

Through the 1980s and 1990s, the emotional tone of treatment within the Minnesota Model further changed from a harsh challenging of the person to a respectful process of inquiry about incongruity of a person's words or behaviors, e.g., using clarifying questions in response to discrepancies between what a persons said yesterday versus what he or she is saying today, what a person reports versus what his or her family members report, and discrepancies between a person's words and his or her behavior. Profane confrontations came to be viewed as disrespectful, ineffective, and professionally inappropriate. The earlier emphasis on personal confrontation by professional staff or one's treatment peers shifted in these decades to a preference for self-education (bibliotherapy), self-evaluation (via structured self-assessment exercises), experience sharing (staff and peer self-disclosure), open-ended and cross-checking questions, and structured opportunities to see oneself in the stories of others.

The story of confrontation within the Minnesota Model and the larger alcoholism field would be incomplete without reference to *constructive confrontation* in the workplace and *family intervention*. Constructive confrontation was a strategy utilized by workplace supervisors to address alcohol-related deterioration in employee work performance. The strategy was heavily promoted in the peak period (1960s-1970s) of occupational alcoholism programming (Trice & Beyer, 1984). Many alcoholism treatment organizations trained local workplace supervisors in the use of this approach which focused on confronting alcohol-related work problems and linking the problem employee to professional assessment and treatment services a via company-sponsored occupational alcoholism consultant.

During this same period, three propositions emerged about family adaptation to alcoholism: 1) alcoholism is a family disease, 2) the homeostasis of the alcoholic family is maintained through elaborate defense mechanisms of all family members, e.g., denial (portrayed metaphorically as the elephant in the living room that no one acknowledges), 3) family members inadvertently support the continued course of alcoholism through their enabling (e.g., excuse-making, over-compensating, rescuing) (White & Savage, 2005). In other words, the early model of alcohol/addiction as a disorder of individual character was broadened to conceptualize the family as pathological and heavily defending the *status quo*. Education of family members encouraged a strategy of "tough love" that was thought to speed up the day when the alcoholic would "hit bottom" and initiate recovery.

In 1973, Reverend Vern Johnson proposed use of a technique of family "intervention" through which the bottom could be raised to meet the alcoholic. In this technique, family and significant others staged a professionally-facilitated confrontation with the addicted individual to share detailed feedback on the person's drinking and its effects on others and to request that the individual take specific actions to resolve his or her drinking problem. The technique gained considerable prominence when First Lady Betty Ford entered alcoholism treatment in 1978 following a family intervention organized by her daughter, Susan Ford Bales. Family intervention became quite popular and developed as a sub-industry within the field of addiction treatment (Twerski, 1983).

Subsequent Developments There were some important transition points in the history of confrontation techniques emerging from early TCs. The first was the extension of confrontation used to treat hard-core street addicts to the treatment of individuals with less severe problems and in some cases very fragile defense structures, e.g., adolescents, persons with severe mental illness. A second transition point was the shift in the use of confrontation within a close-knit peer community in which everyone both delivered and received verbal confrontations, to the use of one-way confrontation within a hierarchical professional counseling relationship in which the client, but not the staff, could be confronted. A third transition was of confrontation from voluntary participation in a closed, supportive community to its injection into mandated treatment and relationships of extremely disproportionate power.

These transitions heightened the potential for abuse and harm emanating from confrontation techniques. Such potential for harm increased as these techniques were adopted within total institutions, e.g., juvenile boot camps and prisons. David Deitch, a leader and astute observer of the TC movement, lamented in the early 1980s that the explosive spread of the TC model had regressed to "inane cruelties" that constituted a "caricature of the negative elements of Synanon, without its redeeming qualities" (Deitch & Zweben, 1981). Deitch contended that the original art form of the Synanon game and its placement within a rich cluster of group-oriented self-awareness processes and the mutual affection and support within the Synanon community mutated in other settings to a singular technique that was little more than a "verbal fistfight" (Deitch, 2006).

In response to growing criticism of confrontation techniques, particularly when applied to marginalized populations (Hall, 1993), these techniques softened in the 1980s and 1990s as 1) the TC was adapted for adolescents, 2) the percentage of professional staff increased, 3) lengths of stays shortened, and 4) outpatient services were expanded. Group technique within the TC evolved from "one of harsh confrontation to one of dialogue and discussion" (Broekaert, Vadevelde, Schuyten, Erauw, & Bracke, 2004). This softening did not, of course, end issues of ineffectiveness, harm and abuse. Perhaps most controversial was the application of confrontation techniques with juveniles in diversion programs such as Scared Straight and in extended treatment programs such as The Seed and Straight, Inc.—all of which have come under severe criticism for exaggerating program benefits while remaining silent about or minimizing program risks (Szalavitz, 2006). The abuses within the troubled teen industry led to the creation in the 1990s of such reform-minded organizations as Families Against Destructive Rehabs.

Early claims of the superior effectiveness of confrontation and counter-claims that it was ineffective and potentially harmful relied primarily on statement of opinion buttressed by anecdotes. With the emergence of more science-grounded treatment approaches in the 1980s and 1990s came studies that began to tip the scales of this debate. Two recent reports, however, suggest that confrontation still has its proponents. A 2001 study on staff attitudes toward addiction treatment found that 46% of those surveyed agreed that "confrontation should be used more" (Forman, Bavasso & Woody, 2001), and a 2004 ethnographic survey of adolescent addiction treatment in the United States commonly encountered programs that were "explicitly designed to demean and humiliate" (Currie, 2004, p. 161).

Scientific Evidence on Confrontation

As the preceding history reflects, the use of confrontation in addiction treatment was based not in science, but in a confluence of cultural factors and personalities. It was primarily an American phenomenon, with very limited diffusion to other nations. We turn now to a review of relevant science on the outcomes of confrontational therapies and their conceptual underpinnings.

An Addictive Personality?

As described earlier, Tiebout's primary rationale for authoritarian confrontation was his belief that people with alcohol and drug use disorders possess a characteristic pathological personality structure involving immaturity and egocentricity, which rendered them incapable of perceiving reality. This addictive personality was alleged to include a cluster of ingrained defense mechanisms such as denial and rationalization, as well as outright dishonesty. Aggressive high-volume confrontation was believed to be the only way to break down or through the formidable wall of defenses. This thinking was subsequently extended to family members as well, alleging that an aberrant "co-dependent" personality rendered them equally pathological as their addicted loved ones (Schaef, 1992; Wegscheider-Cruse & Cruse, 1990).

There never has been a scientific basis for believing that people with substance use disorders, let alone their family members, possess a unique personality or character disorder. Quite to the contrary, research on virtually any measure reflects wide diversity of personal characteristics among people with addictions, who are about as diverse as the general population, or as snowflakes. Studies of defense mechanisms among people in alcohol treatment have found no characteristic defensive structure, and higher denial was specifically found in a clinical sample to be associated not with worse, but with better treatment retention and outcomes (Donovan, Hague, & O'Leary, 1975).

What might account, then, for the robust belief in an addictive personality with characteristic immature defense mechanisms, a professional view that persisted for decades? Surely the writings and speeches of Tiebout and others were not in themselves sufficient to crystallize this view. Counselors genuinely experienced their clients as inevitably mired in denial. If their clients did not walk through the door all the same, how did this belief become so widespread?

An answer, perhaps, is that confrontation and denial form a complementary and self-perpetuating cycle. Defensiveness is a normal human response when one is accused, demeaned, labeled, disrespected or threatened. In other words, suspicion and confrontation are self-fulfilling prophecies. Confronting evokes client defensiveness, which in turn appears to confirm the diagnosis and bolsters the belief that such clients are typically defensive and intransigent. Clinical experiments have demonstrated that clients' levels of resistance are very much under the control of the counselor, and influenced by therapeutic style (e.g., Miller, Benefield, & Tonigan, 1993). Counselors can drive resistance up and down within the same session and client, simply by switching back and forth between a directive-confrontive and a listening-supportive style (Patterson & Forgatch, 1985).

It was also believed that the emotions and other reactions that are predictably evoked by confrontation were therapeutic. Again research paints a different picture. Expressed resistance in counseling sessions predicts a lack of subsequent behavior change (Miller et al., 1993), a finding that would not be intuitively surprising to most counselors. It makes little sense, then, to counsel intentionally in a way that increases client resistance and defensiveness.

If this line of reasoning is sound - that confrontation evokes resistance which in turn predicts a lack of change - then confrontational counseling would be expected to have a poor track record in outcome research. What do treatment outcome studies show?

Efficacy of Confrontational Counseling

Some of the first data on the effects of confrontational counseling came not from substance abuse treatment, but from research on the more general outcomes of encounter groups. Few differences or beneficial effects were found across a range of different encounter group styles. There was one style of group leader, however, who stood out from all the rest,

and did so by producing an uncommonly high level of harmful outcomes: the aggressive confrontational leader (Lieberman, Yalom, & Miles, 1973).

The clearest evidence, however, regarding the efficacy of a treatment (or lack thereof) comes from randomized clinical trials, a number of which have specifically focused on confrontational therapies. The earliest of these was conducted in an inpatient alcoholism treatment facility near Bergen, Norway, where 46 patients were randomly assigned to receive or not receive an intensive "encounter group" experience in addition to treatment as usual (Bjørnevoll, 1972). Contrary to prediction, no significant difference was observed in drinking outcomes at 6 months, with the control group showing a slightly higher abstinence rate.

In the first U.S. randomized trial, which was conducted in Mississippi (P. M. Miller, Hersen, Eisler, & Hemphill, 1973), confrontational group therapy was used as a comparison group in a study of aversion therapy. Men in inpatient treatment for alcoholism.showed no better outcomes when assigned to confrontational therapy versus electric shock aversion therapy. Another randomized trial compared behavioral group therapy with a confrontational group designed to trigger insight (Pomerleau, Pertschuk, Adkins, & Brady, 1978) The drop-out rate was four times higher from the confrontational group, and even among treatment completers there was no significant difference in outcomes, with the direction favoring the behavioral group. In a small study, MacDonough (1976) similarly compared outcomes for alcoholism patients on a behavioral (token economy) ward versus those in intensive confrontational therapy. Contrary to prediction, the improvement rates were 50% and 0%, respectively. A randomized trial in Australia found no outcome differences between those treated by a 7-week "didactic, confrontational approach" versus a minimal intervention consisting of a single session of advice (Sannibale, 1989).

In a Canadian study (Annis & Chan, 1983), 100 adult offenders with substance use disorders were randomly assigned to routine institutional treatment or an intensive 8-week confrontational group therapy. Overall, the added confrontational therapy group produced no better outcomes than those of the control group receiving institutional treatment as usual. There was evidence, however, that offenders with low self-esteem were differentially harmed by the confrontational therapy, showing higher rates of recidivism when placed in this treatment.

A quasi-experimental study (Willenbring, Olson, & Bielinski, 1995) compared outcomes for inpatients receiving "a combination of persuasion, health education and gentle confrontation" (p. 339) versus a group of patients referred elsewhere (primarily to medical care) because admissions to the inpatient unit were temporarily closed. No significant differences in drinking outcomes were reported, but treated patients had significantly more rehospitalizations than did referred patients. A nonsignificant trend indicated more deaths in the referred group.

Two inpatient alcohol treatment programs were compared in a randomized clinical trial with 137 older patients treated at a Veterans Affairs Medical Center in Dallas, Texas (Kashner, Rodell, Ogden, Guggenheim, & Darson, 1992). One was run by empathic staff and emphasized the development of self-esteem. The comparison traditional-care program emphasized confrontation of patients with past failures and current problems. At 12-month follow-up, those treated in former program showed an abstinence rate more than double that for patients treated in the confrontational program.

Two reports evaluated a 15-hour "DWI therapy workshop" that used "confrontation to develop personal awareness". Over 18 months of follow-up, there were no significant differences in outcomes for offenders randomly assigned to the DWI therapy workshop, as compared with an untreated control group given home-study alcohol education materials.

Another clinical trial directly compared confrontational versus client-centered counseling styles (Miller et al., 1993). Problem drinkers were randomly assigned to one of these two therapeutic styles, both of which were delivered by the same counselors. Those assigned to the client-centered condition showed larger reduction in alcohol use (69% vs. 41%), although with a small sample this difference was not statistically significant. Because the same counselors delivered both styles and differed in their skillfulness in doing so, the authors analyzed

audiotapes of counseling sessions to study what was actually done in counseling. They discovered that a single therapist response predicted how much clients were drinking a year later (*r* = .65): the more the counselor confronted, the more the client drank.

Videotape Self-Confrontation

Another set of clinical trials focused on a particular form of confrontational intervention. In the 1950s, a French psychiatrist named Carrère introduced a procedure called “cinematographic psychoshock.” He videotaped patients while they were grossly intoxicated and undergoing detoxification, then showed them the film while they were sober as a “self-confrontation.” He optimistically reported that 45% of 65 patients given the treatment had remained abstinent for an unspecified period of follow-up (Carrère, 1954, 1958).

In the first randomized trial of this method, however, self-confrontation triggered increased treatment drop-out (56% vs. 10% in a control group) without producing therapeutic benefit, even among those who remained (Schaefer, Sobell, & Mills, 1971). In the videotape self-confrontation condition, 100% relapsed shortly after discharge. Other trials reported a high relapse rate shortly after the self-confrontation therapy, and no benefit of videotape self-confrontation when added to treatment as usual (Lanyon, Primo, Terrell, & Wener, 1972). Treating alcoholism at a state hospital, Faia and Shean (1976) randomly assigned lower-social-class patients to a confrontational “aversion” therapy or to a treatment-as-usual discussion group requiring comparable time. The aversion treatment began with a one-hour videotaped interview with two therapists who “made every effort to elicit defensive reactions by confronting him with his self-defeating behaviors.” The tape was then edited to 25 minutes containing the most conflictual parts, and in subsequent sessions the patient was forced to watch the tape while the two therapists kept up “continuous verbal prodding and confrontation” (p. 395). Follow-up at 6-9 months indicated abstinence rates of 14% in the confrontation group, and 25% in the control group, not a statistically significant difference. In several other studies, adding videotape self-confrontation to treatment produced no significant change in drinking outcomes (Vogler, Weissbach, Compton, & Martin, 1977; Vogler, Weissbach, & Compton, 1977; Baker, Udin, & Vogler, 1975; Crawford, 1982). Another study noted that videotape self-confrontation produced strong negative emotional responses in patients, particularly low self-esteem (Paredes, Ludwig, Hassenfeld, & Cornelison, 1969).

A different use of videotape confrontation was reported by Annis (1979). Within a minimum security correctional facility, 150 inmates were randomly assigned to usual institutional conditions (control group) or to daily “intensive, highly confrontational, two-hour 'awareness groups'” (Annis, 1979)(p. 6). Half of those in the confrontational therapy were further assigned to watch videotape of the prior session and received confrontational feedback. Relative to the control group over a year of follow-up, those in the confrontation group (with or without video feedback) showed no better outcomes on any measure including employment, alcohol and drug use, arrests, or re-incarceration. Contrary to prediction, however, those who received confrontational treatment showed significantly lower self-esteem. Davis (1972) similarly found no significant improvement in outcomes with outpatient confrontational group sessions reviewing tapes of prior sessions, as compared with individual psychotherapy.

The Johnson Institute Intervention

As described earlier, a particularly potent form of confrontation was introduced by Rev. Vernon Johnson (Johnson, 1973, 1986). He worked with family members and significant others concerned about a loved one with alcohol/drug problems who refused to seek help. They were coached and prepared for a surprise group meeting in which each of the concerned others would confront the person with their concerns and the ways in which his or her alcohol/drug use had

impacted them. Sometimes they would also announce consequences that would ensue if the person did not enter treatment.

Early uncontrolled and anecdotal reports suggested that "the intervention," when completed, was remarkably effective in engaging unmotivated alcoholics in treatment (Logan, 1983; Loneck, Garrett, & Banks, 1996). One study found, however, that of families being prepared for a confrontational Johnson intervention, 71% decided not to go through with it (Liepman, Nirenberg, & Begin, 1989).

A large clinical trial randomly assigned 130 concerned significant others to receive one of three forms of counseling: Al-Anon facilitation, the confrontational Johnson intervention, or a behavioral therapy (community reinforcement and family training) (Miller, Meyers, & Tonigan, 1999). Of those counseled in the Johnson approach, 70% declined to go through with the confrontational meeting, replicating the earlier report by Liepman (1989). Treatment engagement rates did not differ significantly for the Al-Anon and Johnson groups (21%), whereas those receiving behavioral treatment showed a threefold increase in engagement (64%). In another randomized trial (N = 278), a modified Johnson Institute intervention offered prior to discharge from inpatient alcoholism treatment had no significant impact on post-treatment abstinence (Ino & Hayasida, 2000).

MADD Victim Impact Panel

Seeking to reduce the frequency of recidivism, Mothers Against Drunk Driving (MADD) developed an intervention termed the Victim Impact Panel (VIP) in which drunk drivers are confronted with the real-life consequences caused by other offenders. People whose lives have been devastated by a drunk driver, often through the loss of a loved one, volunteer to speak to an auditorium of offenders, who typically are court-ordered to attend. The presentations are usually heart-rending, with high emotional impact from these first-person stories.

Does attending a MADD-VIP prevent future offenses? One study followed 6,702 drunk driving offenders who reported whether or not they had been mandated to attend a VIP (C'de Baca, Lapham, Liang, & Skipper, 2001). Among first offenders, VIP attendance had no effect on the likelihood of a subsequent offense. Among female repeat offenders, however, those who attended a VIP were twice as likely to be re-arrested for drunk driving, even after controlling for other risk factors. The study was uncontrolled, however, and a more definitive trial was recently conducted by Woodall and colleagues (Woodall, Delaney, Rogers, & Wheeler, 2000). In this study, judges were persuaded to randomly assign drunk driving offenders to attend or not attend a VIP in addition to the usual legal consequences. The findings were similar. Among first offenders there was no effect on the likelihood of recidivism, but for those with more than one prior offense, attending the VIP was associated in both men and women with significantly higher rates of repeat offense.

Why were such interventions ever expected to work? The underlying mental model for confrontation seems to be that "if you can just make people feel *bad* enough, they will change." Confrontational strategies have been designed to make clients feel scared, ashamed, or humiliated, with the assumption that such experiences are curative. In the Woodall study, exit interviews with offenders leaving the MADD-VIP experience confirmed that in general they felt terrible about themselves: embarrassed, ashamed, humiliated, guilty. The result was not less, but more drunk driving.

Discussion

Reviewing four decades of treatment outcome research, we found no persuasive evidence for a therapeutic effect of confrontational interventions with substance use disorders. This was not for lack of studies. A large body of trials found no therapeutic effect relative to control or comparison treatment conditions, often contrary to the researchers' expectations.

Several have reported harmful effects including increased drop-out, elevated and more rapid relapse, and higher DWI recidivism. This pattern is consistent across a variety of confrontational techniques tested. In sum, there is not and never has been a scientific evidence base for the use of confrontational therapies.

An Alternative to Confrontation

The confrontational counseling style that evolved in U.S addiction treatment in the latter half of the 20th century was first and foremost authoritarian. Clients were viewed as out of touch with reality, dishonest, incapable of responsible self-direction, deficient in knowledge and insight, and pathologically defended against change. The counselor's role was one of correcting error, combating delusion, taking charge, educating, breaking down defenses, and being the client's link to reality. The fundamental message to clients was that "I/We have what you need," and the task was essentially one of installing missing pieces, the clients' deficits.

A mirror opposite of authoritarian confrontation is the empathic, client-centered way of counseling that was introduced by psychologist Carl Rogers (Rogers, 1980). It is a collaborative partnership that respects the client's capacity for and inalienable right to self-determination. The counselor's role is to hear and understand the client's dilemma, and evoke the client's own motivations for change (Miller & Rollnick, 2002). Rogers trusted in the natural desire and ability of people to grow in a positive direction given the proper conditions. He taught that when people feel unacceptable as they are, they are immobilized and unable to change (Rogers, 1959). Experiences of shame, guilt and humiliation favor the status quo: more of the same. Indeed, if suffering cured addiction, there wouldn't be any. What people need instead, Rogers believed, is to experience understanding and acceptance, enabling them to see themselves as they really are. Here is the paradox: that in experiencing understanding and acceptance as they are, people are freed to change. Are human beings really wired in such a strange way?

To test his theory, Rogers carefully defined three conditions that he believed a counselor should provide in order to foster positive change: empathy, honesty, and acceptance. Of these, empathy has been most studied, and perhaps most misunderstood. The word "empathy" could imply having had similar experiences that allow one to understand and identify with the client. It is a very consistent finding, however, that counselors who are themselves in recovery are neither more nor less effective in treating addictions (e.g., Project MATCH Research Group, 1998). Empathy might also be thought of as a feeling, as sympathy with the person's condition. What Rogers meant, however, was a definable and learnable counseling skill, the ability to listen to one's clients and reflect back to them the meaning contained in what they say (Truax & Carkhuff, 1967). It is an art that looks simple when done by someone who is good at it, but in fact accurate empathy is a complex skill at which one can continue to improve throughout a lifetime of practice.

Rogers himself never undertook treatment of addictions, but his client-centered counseling methods have been studied by others in this field. Ends and Page (1957) studied outcomes for clients assigned to one of three kinds of group therapy for alcoholism: client-centered, psychoanalytic, or learning theory, all led by the same therapists. The largest improvement at 12 and 18-month follow-up was found for those treated in the client-centered format.

In two studies, clients with alcohol problems were randomly assigned to counselors who varied in their level of skill in client-centered counseling. One study involved nine counselors, all of whom were delivering the same manual-guided behavior therapy for problem drinkers (Miller, Taylor, & West, 1980). Before collecting outcome data, their supervisors independently rank-ordered the nine counselors on their skill in accurate empathy, based on observation (via one-way mirror) of treatment sessions. Inter-rater agreement was high, and when follow-up data became available, client outcomes were examined. Figure 1 shows the percentage of each counselor's case load who were unimproved at 6 months, with counselors arranged from most

(1) to least empathic (9). The proportion of poor outcomes varied from zero (for Counselors 1 and 3) to 75% (Counselor 9). As is apparent, although the clients were all ostensibly receiving the same behavior therapy, the single best predictor of their post-treatment drinking was the counselor to whom they had been randomly assigned. Specifically, the more empathic their counselor, the less clients were drinking at 6, 12, and 24 months (Miller & Baca, 1983; Miller et al., 1980). A larger multisite trial similarly found significant outcome differences across the caseloads of counselors delivering standardized manual-guided treatments, despite intensive training and monitoring (Project MATCH Research Group, 1998).

In a second study randomly assigning cases the counselors, Valle (1981) studied counselors' level of skillfulness in providing the conditions of client-centered counseling (empathy, honesty, acceptance). Figure 2 shows relapse rates in the caseloads of counselors with low, medium, and high levels of client-centered skills. Once again, a primary determinant of clients' outcomes was the counselor to whom they had been randomly assigned. At 6 months the likelihood of relapse was 4 times higher with low relative to high-empathy counselors, and even at 24 months the ratio remained over 2 to 1.

These counselor differences are some of the largest therapeutic effects found in the substance abuse treatment literature. We believe that the evidence supports using skillfulness in accurate empathy as a central qualification when hiring new addiction counselors (Miller, Moyers, Arciniega, Ernst, & Forcehimes, 2005).

More recently, the client-centered method of motivational interviewing has come to be widely used in the treatment of substance use disorders. Motivational interviewing is essentially an evolution of Rogers' humanistic counseling style, manifesting an empathic, respectful, and collaborative approach. A large body of randomized clinical trials now supports the efficacy of this approach in treating alcohol/drug problems (Hettema, Steele, & Miller, 2005).

Rethinking Confrontation

The clinical method of motivational interviewing has historically been taught as an alternative to confrontation, a diametrically opposite style (Miller & Rollnick, 1991). In watching demonstrations of this approach in workshops, however, counselors have at times observed, “This is actually *very* confrontational.” Exploring just what they meant by this led to a different way of conceptualizing what confrontation is, and we believe it is time to rehabilitate this concept.

In its etymology, the word “confront” literally means “to come face to face.” In this sense, confronting is a therapeutic *goal* rather than a counseling style: to help clients come face to face with their present situation, reflect on it, and decide what to do about it. Once confronting is understood as a goal, then the question becomes how best to achieve it. Getting *in* a person's face is rarely the best way to help them open up to new perspectives. There is, as Hazelden observed in its 1985 recanting of aggressive confrontation, “a better way” (Hazelden Foundation, 1985). People are most able and likely to re-evaluate reality within safe, empathic, supportive and nonjudgmental interpersonal relationships that do not necessitate defensiveness.

The confusion of confrontation as a therapeutic *goal* versus a harsh counseling *method* continues to create confusion by mixing together quite diverse treatment approaches (Polcin, 2003). A recent Romanian study (Mihai, Damsa, Allen, Baleydier, Lazignac & Heinz, 2007) reported outcomes of having patients view videotapes of themselves that had been made while they were suffering *delirium tremens* during alcohol withdrawal. This was introduced by the authors as an “unusual” treatment method, without any reference to the ten previously-conducted randomized clinical trials of videotape self-confrontation described earlier in this review. Unlike prior trials, Mihai and colleagues reported significantly lower relapse rates in patients randomly assigned to the videotape exposure group (though it should be noted that all follow-up data were collected by the first author, who delivered the treatment and was aware of group assignment). The treatment was described as “presenting the tape individually to the

patient after recovery and explaining the symptoms viewed." In an accompanying comment, this was interpreted as a "confrontational" intervention (Bühringer & Hoch, 2007), although the study authors themselves did not use this term to characterize it.

One can imagine a wide range of methods that might be used to pursue a therapeutic *goal* of confrontation - to help clients come face to face with a difficult reality and allow it to change them. The literature thus far points to the consistent failure of an aggressive or authoritarian, in-your-face style of counseling. Allowing patients to view their own detoxification, with gentle expert explanation of the symptoms that are occurring, may have quite a different impact from the confrontational intervention styles evaluated in earlier studies. Giving heavy drinkers personal feedback *by mail* to help them compare their own alcohol use with social norms can significantly reduce consumption, even with no personal contact (e.g., Agostinelli, Brown & Miller, 1995). It is important to separate the goal of helping people to ponder their present reality, from counseling styles that try to force them to do so.

Time for Change

In the addiction field as in the annals of prevention and treatment efforts more generally, there is a long history of iatrogenic insults, of interventions that inadvertently do harm. They are done with the best of intentions, by practitioners who firmly believe that they are helping. The problem is that it is difficult to recognize such practices within one's own era. They are easier to see in retrospect.

It is time to declare a final moratorium on the use of harsh, humiliating confrontational techniques in addiction treatment. It is time to lay to rest once and for all the arrogant notion that we should or even can dismantle other human beings and then put them back together in better and wiser form. With impressive consistency, research tells us that authoritarian confrontation is highly unlikely to heal and may well do harm, particularly to the more vulnerable among those we serve. Within this context, such confrontational treatment is professionally unethical, and is doubly problematic when used with coerced populations such as court-ordered or employer-mandated populations.

American addiction treatment took an aberrant detour and went far afield with confronting in aggressive and even cruel ways. This created a self-fulfilling cycle whereby clients became defensive, thus reinforcing the belief that still more forceful confrontation was required. It is time to conduct a historical self-inventory of such practices, admit that these practices were ill-chosen, end their use, make amends where we can to those injured by such practices, and embrace different practices that are more effective and more respectful. There is now a strong science base for addiction treatment, and a related menu of evidence-based treatment methods that provide ample alternatives (Miller & Carroll, 2006).

It can be difficult to change established mental models. The Hungarian physician Ignaz Semmelweis discovered in 1847 that the deaths of mothers from childbed fever could be dramatically reduced if doctors washed their hands before delivering each baby. His discovery was adamantly rejected, however, and he was fired from his hospital position in Vienna. His subsequent studies demonstrated conclusively that handwashing could virtually eliminate these preventable deaths. He published his findings in a book in 1861, but his data clashed with medical theories of the time, and were widely rejected. Practitioners continued to deny the evidence, rather than facing the terrible truth that they had killed countless women simply by not washing their hands. In 1865, at age 47 Semmelweis was involuntarily committed to a mental asylum, where he was beaten to death two weeks later (Broad & Wade, 1982). Another generation passed before handwashing became routine when attending childbirth, and in the interim thousands of women died needlessly.

As is true for our clients, it is painful sometimes to face reality and change our ways. But it is time, long since time, to wash our hands of authoritarian confrontation, and to listen instead to the co-therapist we have within every client.

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Figure 1

(return to article)

Percentage of Counselors' Cases Unimproved (Miller, Taylor & West, 1980)

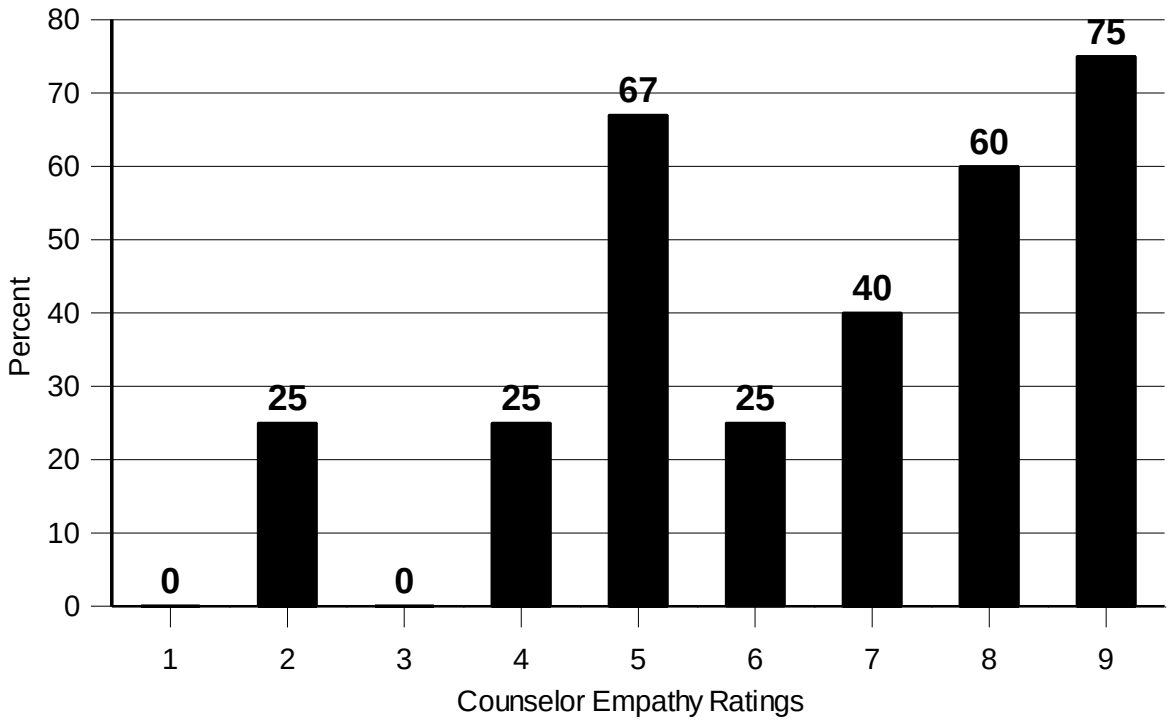
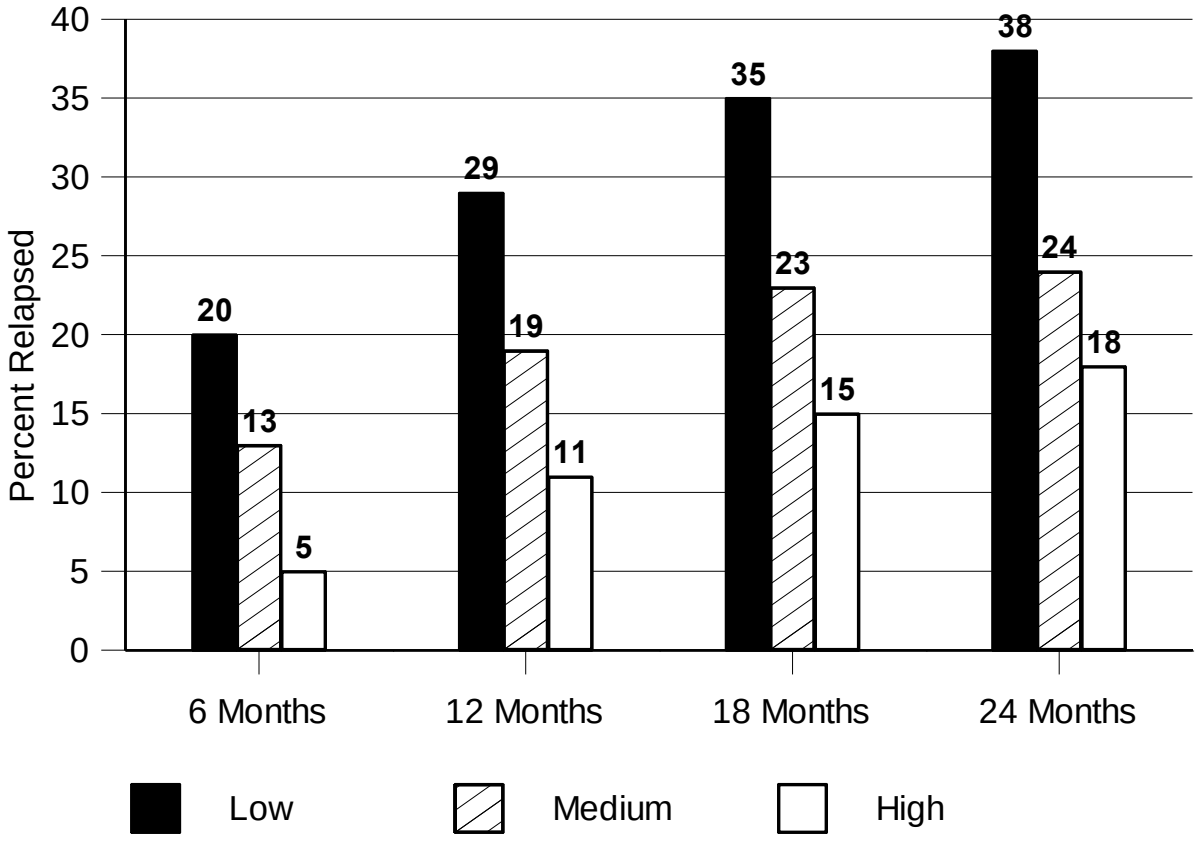


Figure 2 (return to article)
Percentage of Counselors' Clients Relapsed, by Empathic Skill Level (Valle, 1981)



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doi:10.1111/j.1360-0443.2007.01796.x

Conversation with William L. White



In this occasional series we record the views and personal experiences of people who have especially contributed to the evolution of ideas in the journal's field of interest. For over 40 years, William L. White has contributed creatively to the evolution of the American treatment response to alcohol and drug problems. He has also established a reputation as a distinguished historian of this field.

Addiction (A): Tell us something of your personal background before you entered the addictions field.
William L. White (WLW): I was born in 1947 to parents who met while both were serving in the US Army in World War II. My father was a construction worker and my mother was a nurse. I had a large family with more than 20 blood, adopted and foster siblings who shared the close intimacy of a small rural Illinois community. My parents placed great importance on education, having both come from families in which such achievement was denied routinely by life circumstances. I was fortunate to obtain scholarships to Eureka College, a small liberal arts school in Illinois. It was there that I developed a love for learning and an early interest in psychology, sociology and history. There were several influences from these early years that shaped aspects of my subsequent professional life: a public service ethic inspired by my own family and a young charismatic president (John Kennedy), a deep commitment to social change spawned by the American civil rights movement, and a love of writing. As I began my professional life, there was also a sense that my young life had been lived inside a cocoon. I have spent more than four decades since appreciating anew what I experienced within that cocoon; at the same time I have fought to escape its limitations.

FINDING THE ADDICTION FIELD

A: Did you find the addiction field or did the addiction field find you?
WLW: I am one of a legion of people in the late 1960s drawn to an emerging treatment field in the United States out of our own personal or family recovery experiences. That background stirred my early courtship with the field, but other experiences generated my long-term commitment to this work.

A: Could you provide an example of such an experience?
WLW: My first employment in the field was in 1967 with the Illinois Department of Mental Health. During that era of deinstitutionalization, one of my responsibilities was to tour the back wards of aging state psychiatric hospitals to screen alcoholics and addicts for potential community placement. Those visits afforded me a poignant opportunity to witness the care of the addicted in the decades before the emergence of community-based treatment. The depraved conditions in those institutions stirred my activism, as did my interviews and reviews of decades-old charts documenting prolonged institutionalization, bizarre and near-lethal withdrawal procedures, coerced sterilizations, 'shock therapy', psychosurgery and drug insults of unending varieties. Forty years later, I can vividly recall the leather restraints and straightjackets, the hydrotherapy tubs, the over-crowded wards, the stench of urine and paraldehyde and the feeling of utter hopelessness that permeated those institutions. If I had entered the field only a few years later, I would have had no real sense of the horrid conditions that preceded modern addiction treatment.

A: What addiction treatment resources existed at the community level at that point in time?
WLW: There were fledgling alcoholism programs, therapeutic communities and methadone programs, but there were no specialized addiction treatment services in most

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American communities. In the cities in which I was working, I could not even get alcoholics admitted to local hospitals for treatment of acute trauma because of morality clauses in hospital by-laws that prohibited the admission of alcoholics. Institutional ownership of alcohol and drug problems in those years rested with the criminal justice system, so much of my early outreach work was in the city drunk tanks and the county jails. The only welcome sign and haven of comfort for the addicted in most cities was inside the meeting rooms of Alcoholics Anonymous (AA).

A: Is there an incident that typifies your early work during this period?
WLW: There is one that comes immediately to mind. I helped get a man released from the drunk tank of a local city jail, connected him to a local AA group and offered daily support to him and his family. He did amazingly well for a few months, considering the severity and duration of his alcoholism. It was the week of Christmas when, depressed over the gifts he was unable to provide for his wife and children, he sought the balm of an offered bottle. He was jailed later that day for public intoxication and hung himself during the night in the same cell in which I had first met him. Such suicides were common in those years. When I stood before his body and met later that day with his family, I was overwhelmed by my own ineptness and the meager resources I had been able to muster in my offer of assistance. There were no addiction-trained physicians, no detoxification units, no treatment programs, no trained addiction counselors. I was enraged that this man had to die in despair in such a despicable place. I think my commitment to spend my life working in this field began that day.

A: Your work to help found Chestnut Health Systems was an early product of that commitment. How did this come about?
WLW: I worked as a streetworker (what today we would call an outreach worker) and community organizer for the state mental health department and a local mental health center in the early 1970s. The needs I was witnessing as a streetworker, including my outreach in the jails and hospital emergency rooms, informed the types of services I was trying to organize. This led to helping to develop one of thousands of local alcoholism councils that were popping up in those years. Landmark legislation was passed in the early 1970s that channeled federal dollars through the states to local communities to plan, build, staff and operate addiction treatment programs. After almost 3 years of planning, our local council received word in 1972 that we would be funded to open the community's first treatment center. I was invited to work as a counselor at Lighthouse, which was later rechristened Chestnut Health Systems. Within months, I assumed the clinical director position. I should note that advancement in those years was as likely to result from surviving the high staff casualty rate as from one's competence.

A: You have suggested that the exploitation of recovering people is an untold story in the early history of modern addiction treatment.
WLW: We need to acknowledge the contributions recovering people made in birthing and sustaining the field in the days before addiction treatment came of age. There were few guidelines in the 1960s and 1970s on how to screen, select, orient, train and supervise the mostly recovering people recruited to work within newly arising treatment programs. Those hired were paid a pittance, worked unconscionably long hours, and were often discarded when they succumbed to the stress placed upon them. Even among those who survived, many were later pushed out of the field in the rising tide of professionalization. As a field, we have not adequately honored the sacrifices and contributions of that generation of workers.

A: How would you describe the clinical philosophies of treatment during the early 1970s?
WLW: There were few well-developed models of treatment. When Lighthouse opened its doors, we drew from two traditions. Like thousands of others, we visited Hazelden in Minnesota and met with Dan Anderson, Gordy Grimm and Harry Swift, who graciously shared everything about the inner workings of the Minnesota Model. We also drew from Chicago's Gateway House, a second-generation therapeutic community, whose leaders were equally gracious in sharing the details of their clinical operations. It is important to note that there were two addiction fields at this time. There was an alcoholism field and a drug abuse field. Lighthouse faced a unique challenge because we were committed to treating alcoholism and drug addiction in the same facility and through an integrated philosophy of treatment and recovery. Dr Don Ottenberg of Eagleville Hospital in Pennsylvania was championing a similar approach and offered us considerable support. Our advocacy for the integration of these two fields drew a lot of criticism in those days.

THE CHICAGO/WASHINGTON DC YEARS

A: In 1975, you made a decision to return to school. How did you come to this decision?
WLW: All of us reach stuck points in our careers that force us to re-evaluate our relationship with our chosen field. I reached such a point in 1975 and decided, as an alternative to leaving the field, to get into the field even

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deeper. This sparked two further decisions. First, I enrolled in an addictions studies program at a time few such programs existed in the United States. I was able to arrange a Master's program in Addiction Studies through Goddard College that allowed me to use Dr Ed Senay as my primary mentor. Dr Senay was one of the founders of the Illinois Drug Abuse Program and a professor at the Department of Psychiatry at the University of Chicago. My professional maturation began under his guidance. The second decision I made was to expand my experiential knowledge by gaining exposure to different types of treatment modalities, treatment in different cultural contexts and different specialty roles within the field. This led to my relocation to Chicago and a position with the Illinois Dangerous Drugs Commission. My work there provided an understanding of the larger state and national infrastructure of the field and expanded my knowledge and skills in planning, policy development, research and training. My work at the Dangerous Drugs Commission led to my accepting a position as Deputy Director of the National Institute on Drug Abuse's midwest training center and an eventual transfer to Washington DC, where I first gained exposure as a national trainer.

A: You have often talked about the disconnection between policy and planning and the front-line realities of addiction, treatment and recovery. Was that an observation drawn from your Chicago and Washington DC years?
WLW: Yes. My goal for working in Chicago and Washington DC was to learn the inner workings of the state and federal addictions policy institutions. Some incredibly talented individuals crossed my path inside these organizations, but I was struck by the breach between these organizations and the front-line realities of addiction and addiction treatment. I learned that the whole can be less than the sum of its parts. The technical and administrative skills possessed by individuals working in these state and federal agencies were impressive but, when added together, did not result in agencies that had anything other than a veneer-thin understanding of addiction, treatment and recovery. Years later, I joined others calling upon these organizations to increase the depth of that knowledge and to truly become recovery oriented systems of care.

A: Your work within the NIDA's National Training System afforded opportunities to work with front-line counselors from all over the United States. What did you take from this experience?
WLW: This was the first time I began to see myself as serving the larger field rather than a particular program or a particular community, and I got to know the enormous diversity of how treatment was conducted across the United States. I began to define the field in terms of common themes heard in my travels. I would listen and ask myself, 'What does this personal or local story tell me about the evolving character of the field?'. Working with the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Addiction (NIAAA) training systems in those years was a wonderful experience. I learned a great deal about workforce and leadership development from visionaries such as Dr Lonnie Mitchell and George Zeiner. It was exciting being part of the effort to recruit, train and professionalize America's addiction treatment workforce. During this time, I refined the presentation skills that would keep me on the lecture circuit for the next two decades.

TREATMENT IN THE 1980s

A: In 1982, you returned to Illinois to direct a hospital-based addiction treatment program. How would you describe the state of treatment in those years?
WLW: This move was a conscious effort to deepen my clinical leadership skills, and it was a great time to do it. The early 1980s were the glory days of addiction treatment—the height of the destigmatization, decriminalization and medicalization of alcohol and other drug problems in America. This was the pinnacle of recovery as a cultural phenomenon in America—a time when it was cool to be in recovery. Accreditation standards for treatment programs and new addiction counselor certification systems in the 1970s had legitimized addiction treatment. Twelve-Step programs and their alternatives were growing explosively. We even had a First Lady of the United States (Mrs Betty Ford) talking publicly about her recovery from addiction to alcohol and other drugs. It was an amazing time. At the clinical level, it was a period of great innovation—increased sophistication in clinical assessment, the development of specialized programs for women and adolescents and the proliferation of family programs, to name just a few areas. And yet at the larger level, forces were unleashed that would stir a backlash against the field. While treatment reached the mainstream in an unprecedented way in the 1980s, this period marked the rapid commercialization of addiction treatment. Private and hospital-based programs proliferated and consumed all the dollars that the insurance industry was willing to invest briefly in addiction treatment. In this environment, alcoholics and addicts became a crop to be harvested for financial profit. The abuses inside the treatment industry led subsequently to the erosion in treatment benefits and an aggressive system of managed care that led to the collapse of many programs and radically altered the character of addiction treatment in the United

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States. The image of the field has still not recovered fully from such abuses.

'The early 1980s were the glory days of addiction treatment—the height of the destigmatization, decriminalization and medicalization of alcohol and other drug problems in America.'

THE LIGHTHOUSE INSTITUTE AND EARLY BOOKS

A: What led to your return to Chestnut Health Systems in 1986 and the founding of the Lighthouse Institute?
WLW: In 1986 at the hospital where I was working I was struggling without success to create a department of behavioral medicine with its own research and training institute. At a conference I was attending, I shared my frustration in failing to achieve this goal with Russ Hagen, whom I had hired in 1974 and who had gone on to lead Chestnut Health Systems into an organization far beyond anything I could have ever envisioned. Russ called me a few weeks later and invited me to return to Chestnut to create a research and training division. I accepted and became the first staff person in Chestnut's Lighthouse Institute. Within a few years I was joined by Mark Godley, Susan Godley, Mike Dennis, Christy Scott and other senior staff whose projects have brought the Lighthouse Institute to its current status. As more experienced and skilled researchers arrived, I continued to work on some research projects but focused most of my time delivering addiction-related training and consultation services throughout North America.

A: Your first research project at the Lighthouse Institute continued for more than 15 years and exerted a great influence on your professional life. Could you highlight some of what you learned from this project?
WLW: In 1986 I was asked to evaluate Project SAFE (Substance Abuse Free Environment), an innovative project that mobilized the combined resources of addiction treatment and child welfare agencies in more than 20 Illinois communities to intervene with addicted women with histories of abuse or neglect of their children. I served as the lead evaluator of that project until 2002 and was forced to rethink much of what I thought I knew about addiction and recovery. I owe many of my later contributions to what I learned from hours spent interviewing those recovering women and their counselors and outreach workers. To give one example, my traditional training had led me to the belief that motivation for recovery was a pain quotient, that recovery was ignited when the pain of continued drug use surpassed the pain of severing the cherished drug relationship. When I expressed this one day, a Project SAFE outreach worker responded angrily, 'Bill, my clients don't hit bottom; they live on the bottom! Bottom is the norm for them. They have more pain in their lives than you could ever comprehend. The major obstacle to their recovery is not the absence of pain; it is the absence of hope!'. This was one of innumerable lessons I would learn from the remarkable women involved in Project SAFE. My later writings on gender-specific treatment, client engagement and family-centered care all drew heavily from my Project SAFE experience.

A: After almost 20 years working on the front lines, you began what has been a prolific writing career in the field. Was this a difficult transition?
WLW: It was difficult because there was no source of guidance about how to write and publish in this field. Technical and even ethical aspects of such writing all had to be acquired by trial and error unless you were fortunate enough to be coached by one of the field's elders, and even that mentoring was often not comprehensive in its scope. The International Society of Addiction Journal Editors have recently released *Publishing Addiction Science: A Guide for the Perplexed* [1]. This work is an invaluable tool that I wish would have been available when I embarked on my writing career in the 1980s. Anyone serious about writing in this field should own and regularly consult this *Guide*.

A: Shortly after you returned to Chestnut you published your first book, Incest in the Organizational Family. *What was the source of inspiration for this book?*
WLW: It was a very personal form of sense-making. I had helped build some very innovative programs in the 1970s, but then witnessed some of those programs implode at the very time they were receiving considerable external recognition. I saw similar destructive organizational processes in my consultation work with many addiction treatment programs. There seemed to be a propensity for addiction treatment programs to become closed incestuous systems marked by charismatic leadership, ideological extremism, professional and social isolation, and abuses of power that injured both clients and staff. I wrote my first book to illuminate this process and to describe strategies that could prevent or reverse it. I attributed much of this closure process to the derived stigma attached to addiction treatment institutions and the people who work in them [2].

A: How did you come to write the book Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*?*
WLW: Because of my tenure in the field, I was often asked for advice about difficult situations that would

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arise in the life of local treatment programs. Many of these situations involved complex ethical as well as clinical and managerial issues. By the early 1990s, I was concerned about the growing prevalence of ethical breaches in the field and the inadequate level of training our workforce had received in ethical decision-making. There were our early codes of ethics and LeClair Bissell and James Royce had performed a great service to the field by writing the introductory primer, *Ethics for Addiction Professionals* [3], but I felt we needed an ethics casebook that provided a model of ethical decision-making and used real ethical dilemmas to mark the ethical terrain of the field. *Critical Incidents* was released in 1993, and I think it did achieve its goal of heightening the ethical sensitivities and improving ethical decision-making of addiction counselors [4]. I wrote the book that I wish someone would have given me when I first entered the field. I am delighted about its use as a textbook in addiction studies programs and that the ethical decision-making model it contains has been applied to everything from clinical research to addiction publishing [5,6].

A: The second edition of Critical Incidents *included legal annotations provided by Renée Popovits. How did you come to the decision to add these?*
WLW: When I was working on the first edition in the late 1980s, it seemed to me that the treatment field was becoming addicted to money and regulatory compliance. I feared that including discussions of legal issues would reduce the question, 'Is it ethical?' to the question, 'Is it legal?'. As a result, I limited the legal discussions in the first edition. By widely disseminating the first edition, I think the field was prepared for a second edition that integrated discussions of ethics and law within the book's 200 case studies. It also took some time to find a collaborator who had extensive experience dealing with legal issues in addiction treatment. Renée Popovits brought that experience and made significant contributions to the new edition.

A: You also wrote a book on AIDS case management in the early 1990s. How did that project develop?
WLW: That project grew out of my donating addiction-related training services to the AIDS Foundation of Chicago (AFC) to support its consortium model of AIDS case management. The growing interest in replicating this model in other communities prompted a decision by the AFC board to prepare a book on their model. They asked me to take on that project, and I spent more than a year interviewing people with AIDS and their families as well as a large number of AIDS case managers in Chicago. The product of that effort was *Voices of Service, Voices of Survival: AIDS Case Management in Chicago* [7]. My work on the book and my broader work with the AFC were attempts to offer some personal response to the devastation of the early AIDS epidemic.

SLAYING THE DRAGON

A: You are perhaps best known for Slaying the Dragon, *your work on the history of addiction treatment and recovery in America. How did this work begin?*
WLW: I had worked in direct services for almost a decade before stumbling onto the existence of earlier periods of addiction treatment. I felt somehow cheated that such knowledge had not been passed on to me and became curious about the early history of treatment and recovery support groups. I began researching this history in the mid-1970s with the thought that I would write an article on this history for addiction counselors. That research ended up spanning the next 20 years of my life. Every time I thought I had a complete grasp of this story, I stumbled onto a previously unknown episode within the field's history. I hope there will be other histories that will surpass what I have created, but I am very pleased to have written the first comprehensive history of the field and to have published it in a way that it has remained affordable to the lowest-paid workers in the field [8].

A: You must have found that research quite enjoyable, to have sustained it over that many years.
WLW: It became one of the professional loves of my life. First, there was the excitement of historical discovery, particularly in the archival research. I vividly remember unwrapping a document in the Keeley Archives at the Illinois State Historical Society that was still in the original packing papers in which it had been shipped many decades earlier. Inside the packing papers was a log book documenting the histories of more than 130 physicians who had been treated for addiction and had then been hired to work as physicians in one of the more than 120 Keeley Institutes. As I stared at the pages of this document, I knew I had discovered an important and previously unknown chapter in the early history of addiction medicine. It was an amazing feeling. There were also many recent chapters of the history of treatment, such as the rise and fall of Parkside (the largest provider of addiction treatment services in the US prior to its collapse in 1993), that could be acquired only through interviews with key figures. That gave me the opportunity to interview some of the modern pioneers of addiction treatment in America. I valued the information they provided me, but I also grew from my personal encounters with these remarkable individuals. My interviews with people such as Dan Anderson, Vincent Dole

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and David Deitch exerted a profound influence on my own commitment to the field.

'Inside the packing papers was a log book documenting the histories of more than 130 physicians who had been treated for addiction and had then been hired to work as physicians in one of the more than 120 Keeley Institutes. . . . It was an amazing feeling.'

A: Your contributions in writing the history of treatment and recovery in America have been blessed by some special mentors. Could you describe their role?

WLW: The most important of these mentors has been and still is the Harvard-trained historian Ernie Kurtz. I knew of Ernie's definitive history of AA [9] and contacted him in the early 1990s with a request that he review the four chapters I had drafted on AA for *Slaying the Dragon*. That initial contact grew into a sustained mentorship of nearly all my subsequent history work. Ernie emphasized the importance of telling a story chronologically and showed me how to tell a story in context and to personalize and localize a story. He taught me to provide evidence for the accuracy of each story and to carefully separate fact from conjecture. He encouraged me to tell a story from different perspectives. And he told me to stay in contact with my reader—to keep the reader eager to turn the page to find out what would happen next [10]. He also taught me a great deal about interviewing, particularly how to work through weak or distorted memories, and he connected me to a larger network of historical scholars within the addictions arena. Much that I have achieved as a treatment and recovery historian I owe to my mentorship with Ernie Kurtz. Other mentors, role models and important sources of encouragement for my historical writing have included David Musto, David Courtwright, David Lewis, Tom Babor, Tom McGovern, Bob DuPont and Griffith Edwards.

A: You have recently chronicled the history of what you have christened the New Recovery Advocacy Movement in the United States. How would you describe your role in this movement?

WLW: It is a role that has evolved over the past decade. I was interviewed in the spring of 1997 by Bill Moyers for the Public Broadcasting Service (PBS) special *Moyers on Addiction—Close to Home.* In that interview, I predicted a potential surge in organizing efforts by recovering people and their families in response to the restigmatization and renewed criminalization of alcohol and drug problems that had occurred through the 1980s and 1990s in the United States. Within 2 years of that interview, new grassroots recovery advocacy organizations were forming and many of the local affiliates of the National Council on Alcoholism and Drug Dependence (NCADD) were undergoing renewal processes to revive their advocacy roots. I tried to both document and encourage these developments. Since recovery advocates first came together in October 2001 to launch a broad-scale national movement, I have volunteered time to NCADD, Faces and Voices of Recovery (FAVOR), the Johnson Institute and numerous local recovery advocacy organizations as a speaker and writer. My recovery advocacy papers have been posted at the FAVOR website (http://www.facesandvoicesofrecovery.org) and have been published recently in book form, with the proceeds going to support this movement [11].

A: How do you square your role as dispassionate scholar with that of activist?

WLW: There has clearly been tension between my aspirations for objective scholarship and my activist role in this movement. I am, without question, a historian with an agenda. I worried that this activist stance might violate standards of scholarly detachment and objectivity until I found an essay by Aurora Levins Morales entitled 'The historian as curandera' [12]. She suggests several strategies for the activist historian: tell untold or undertold stories, identify misinformation and expose it, ask provocative questions, explore non-traditional sources of historical evidence, portray stories that reveal people as actors rather than victims, reveal complexities and ambiguities and make history accessible to real people. Her essay conveyed more articulately than I ever could the role I was seeking through my historical research and writing. My goal is to use history to change people's lives and to elevate the professional field that has been such an important part of my life. The stories I have uncovered are informative and entertaining, but my interest in them is primarily in the lessons they convey—lessons that can influence individual and institutional decision-making.

A: Could you give an example of such a lesson?

WLW: It is hard to research the history of addiction treatment without being struck by the iatrogenic insults that have been inflicted on people addicted to alcohol and drugs in the name of help. Two things are striking in this history. The first is that most of these interventions were clothed for a time in the mantle of science. In the midst of current calls for evidence-based treatment, I think this history tells us that we need to define carefully and continually what we mean by evidence. The second striking fact is how hard it is to recognize such iatrogenic insults within one's own era. We can look back with smug condescension at 19th-century physicians prescribing

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pounds of cocaine to treat morphine addiction. We can self-righteously proclaim, 'What on earth were they thinking?'. But it gives one pause to wonder how our own clinical policies and practices will be evaluated 50 or 100 years from today. History is a great teacher of caution and humility.

A: It is often said that there are predictable cycles in history. Have you found such cycles, and if so what can we learn from them?

WLW: There are some predictable cycles in drug trends from which important lessons can be extracted. For example, periods of intense stimulant use in a culture are often followed by increases in sedativism, alcoholism and narcotic addiction. If that principle is true, the current methamphetamine epidemic in the United States could bring narcotic addiction into rural communities that have, historically, not experienced this problem. In a similar vein, history tells us that the first alleged scientific reports coming out of any new drug epidemic are notoriously unreliable, as are reports of miracle breakthroughs in the treatment of addiction. There are also cycles of intragenerational learning about particular drugs, but there is little evidence of intergenerational learning—a pattern that underlies the cyclical rise, demise and resurgence in particular drug choices. There is value in studying such patterns and cycles, but the problem with seeing everything within this framework is that it can blind us to patterns that are fundamentally new.

A: How did you come to collaborate on writing a history of recovery among Native American tribes?

WLW: That project began when I first met Don Coyhis, the Director of White Bison, Inc. and leader of the Native American Wellbriety Movement. I mentioned to Don that in my research for *Slaying the Dragon* I had encountered items of evidence suggesting Native American recovery circles dating to the 1730s—200 years before the founding of AA and 100 years before the Washingtonian Revival. I suggested that this history could contribute to the cultural renewal processes that were unfolding in Indian communities across North America and encouraged him to research and write this history. He, in turn, challenged me to help with the project. In the course of that research, I was forced to re-evaluate everything I had been taught in my tenure in the addictions field about the historical relationship between alcohol and Native Americans. The book *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery* [13] debunks many of the 'firewater myths' that have stigmatized Indian communities and misidentified the sources of and solutions to Indian alcohol problems. Perhaps most importantly, the book details the ways in which Indian leaders resisted and continue to resist the infusion of alcohol into Native cultures, and it tells the stories of abstinence-based religious and cultural revitalization movements to contain alcohol-related problems. The process used to create this book—its oversight by Native American Elders, the use of oral tribal histories as well as archival documents, submission of a draft of the book to Native American recovery leaders—was different than anything I have ever experienced as a writer and was deeply rewarding. I am pleased that, by donating all proceeds from the book to the Native American Wellbriety Movement, we were able to break the common pattern of scholars exploiting Indian communities to further their careers without returning the fruits of their labor to these communities.

A: What additional history-related projects do you have on the drawing-board?

WLW: I have three long-term projects that allow me to transmit the findings of my historical research to the field. These include my regular history columns in *Counselor* and in *Rising: Recovery in Action* (the quarterly newsletter of Faces and Voices of Recovery) and my photo-history series in *Addiction.* The Native American recovery history project has also spawned two follow-up projects, one on the history of addiction recovery in African American communities and the other a history of addiction, treatment and recovery among American women. Each of these will require 3–5 more years of research and writing. My collaborators and I have already started conveying some of the history and implications from this research through the addiction counselor trade journals.

A: You publish your work in books and peer-reviewed journals, but you also invest considerable time writing for addiction treatment trade journals, recovery advocacy newsletters and writing papers that you leave in public domain and allow to be posted on multiple Internet sites.

WLW: Contributing to the scholarship of the field is important to me, but I have tried to remain faithful to my primary audiences: people in recovery, recovery advocates and those working on the front lines of treatment. There is considerable talk about knowledge transfer from research to practice and the need for education of the public and policy makers, but those of us in the research community tend to restrict ourselves to communication channels that reach each other but do not reach those who should be the ultimate consumers of our work. I think we underestimate the potential power of 'grey literature', and I have tried to reach my audiences through this medium. I have also enjoyed inviting many of my research colleagues to collaborate with me in this writing for 'real people'.

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RECOVERY MANAGEMENT

A: You have called for a recovery-focused redesign of addiction treatment. How did you come to develop this perspective?

WLW: I think of it as my epiphany in Dallas. In the late 1990s, I was interviewing a 94-year-old man with 54 years of sobriety in AA about the early relationship between AA and 'drying out' homes in the South-western United States. During a break in the interview, he asked me about this 'research stuff' I did. I explained that I was part of a research institute that interviewed people after treatment and noted with some enthusiasm that we had completed some studies that had followed people for 5 years after treatment. He seemed amused by my pride in knowledge of such a short period of sobriety and asked what the field's research had to say about characters like him. I thought about his 50+ years of sobriety and humbly reported that we did not even know he existed—that we knew next to nothing about people in such long-term recovery. I later reflected on his question a good deal and realized that my colleagues and I had spent most of our lives studying addiction and in more recent years studying this thing called treatment, but that, from the standpoint of science, we knew very little about people's lives in recovery. It dawned on me that perhaps it was time we studied the solution to addiction that exists in the lives of millions of individuals and families. It was at this point that I began to write about switching from pathology and intervention paradigms toward a recovery paradigm as the organizing center for the field, and to call for a recovery-oriented research agenda [14]. It has been exciting to see such a recovery research agenda pursued by my colleagues at the Lighthouse Institute and by researchers such as Keith Humphreys, Alexandre Laudet, Jon Morgenstern, Jim McKay and others who are illuminating the long-term recovery process.

'. . . I began to write about switching from pathology and intervention paradigms toward a recovery paradigm as the organizing center for the field, and to call for a recovery-oriented research agenda.'

A: This seems to have bridged into your work in what you have called recovery management. How did this work begin?

WLW: In 1998, the Illinois State Legislature funded a collaborative effort by Fayette Companies and Chestnut Health Systems to reassess the design of addiction treatment. The goal was to find more effective approaches for people with severe and complex addictions who were cycling repeatedly through the treatment system without achieving sustainable recovery. I was asked by Mike Boyle and Russ Hagen to help lead this project and began what was for me a rigorous evaluation of what treatment as currently designed can and cannot achieve realistically. The Behavioral Health Recovery Management (http://www.bhrm.org) project became part of a larger movement to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management. Through that project, I have tried to answer two provocative questions: (1) how would we treat addiction if we *really* believed that addiction was a chronic disorder; and (2) how would we treat addiction if treatment professionals and treatment institutions were paid only for successful recoveries? [15,16]. This early work opened opportunities to collaborate with the efforts of visionary leaders such as Dr Tom Kirk from the Connecticut Department of Mental Health and Addiction Services and Dr Arthur Evans from the Philadelphia Department of Behavioral Health, who are attempting to transform addiction treatment into recovery-oriented systems of care.

A: Addiction as a chronic disorder?

WLW: The research community is making significant contributions in helping the treatment field conceptualize addiction as a chronic disorder. McLellan and colleagues' seminal 2001 article in the *Journal of the American Medical Association* will probably stand as a historical tipping-point in this effort [17]. There is considerable interest in extending the current acute care model of intervention within a more time-sustained service continuum that engages people at an earlier stage of problem development and facilitates the transition from recovery initiation to sustained recovery maintenance. My colleagues and I at the Lighthouse Institute are particularly interested in the effects of post-treatment monitoring, sustained recovering coaching, assertive linkage to communities of recovery and early reintervention on long-term recovery outcomes [18,19].

A: One of your interests has been to map what you refer to as 'the varieties of recovery experience': could you describe that work?

WLW: Common to my recovery advocacy work and my work in recovery management is the proposition that there are multiple pathways of long-term addiction recovery. I collaborated recently with Ernie Kurtz on a monograph that tries to convey what we know about such pathways and styles of recovery from the standpoint of history and science [20]. In this work, we plotted variations in the frameworks of recovery (religious, spiritual and secular), the scope and depth of recovery, styles and contexts of recovery initiation and differences in recovery identity and relationships. We also tried to answer the questions of when recovery was stable and durable and whether recovery was ever completed. Our goals were to

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both summarize current knowledge about recovery for addiction counselors and recovery advocates and to stimulate future recovery-focused research.

A: You have also been very interested in the history of Alcoholics Anonymous and other recovery mutual aid societies.
WLW: I have been fascinated by the history of AA and pre-AA recovery mutual aid societies from Native American recovery circles of the 18th century through other early groups such as the Ribbon Reform Clubs, the Keeley Leagues and the Drunkard's Club. I have also collaborated with Ernie and Linda Kurtz on cataloguing the growth of adjuncts and alternatives to AA [21]. What I see in the international history of such groups is an unrelenting source of rebirth that emerges from the very experience of addiction. Often abandoned by family and society, people suffering from addiction have been reaching out to one another for mutual recovery support for more than 250 years. Many of the resulting groups found viable strategies of personal recovery, but very few have found a way to sustain themselves as organizations.

A: To what do you attribute AA's growth and resilience?
WLW: There are some unique aspects to AA's program of recovery that have contributed to its growth, but I think AA's resilience as an organization rests not in the Twelve Steps but in the Twelve Traditions. AA groups forged unique solutions to the problems that had led to the self-destruction of earlier recovery support groups. AA found solutions to the problems of mission diversion, charismatic leadership, divisive political and religious controversies, money, property and professionalism. The Twelve Traditions of AA are the foundation of one of the most unique and resilient organizational structures in human history.

A: Your work in recovery management has led you to challenge many mainstream practices in addiction treatment. How did you come to take on the practice of administrative discharge?
WLW: At the time my colleagues and I first looked at this, 18% of all clients admitted to addiction treatment in the United States were discharged administratively, which is a euphemism for being kicked out—mainly for confirming their diagnosis via alcohol or other drug use. We have argued that discharging clients administratively from addiction treatment for alcohol and other drug (AOD) use is illogical and unprecedented in the health-care system. There is no other sector of health care in which you can be extruded for exhibiting a symptom of the condition for which you have just been admitted. At best, this practice reflects a fundamental misunderstanding of the role of volition in addiction and recovery. At worst, it is the endgame in a process of escalating negative countertransference. Administrative discharges can also reflect power struggles over arbitrary rules that have little if any nexus to the prospects or processes of recovery or to safety issues within the treatment milieu. We challenged this practice and offered clinical alternatives to administrative discharge [22]. Given the number of people I threw out of treatment in my early career, I consider my work in this area a form of amends.

A: You also challenged the use of 'Treatment Works' as the field's most central organizing slogan. What was your rationale for challenging this slogan?
WLW: Addiction treatment is a godsend for hundreds of thousands of individuals and families, but its role in the recovery process is misrepresented to the public through the slogan 'Treatment Works'. I object to the slogan because it conveys erroneously the existence of a singular, static entity called 'treatment' that is consistent in character and quality. The slogan fails to distinguish those individuals for whom addiction treatment is most appropriate from those who are likely to resolve AOD problems without professional intervention or who could even be potentially harmed by treatment. Perhaps most importantly, the slogan 'Treatment Works' misrepresents the highly variable and complex outcomes of addiction treatment and shifts the focus (and responsibility for recovery) from the addicted/recovering person to the treatment professional. In my writings, I have advocated the use of alternative slogans that extol the power of personal choice and responsibility, are recovery- and family-centered and scientifically defensible, and that incorporate a menu of catalytic metaphors drawn from diverse medical, religious, spiritual and cultural traditions. My fear is that, by exaggerating what a single brief episode of treatment can achieve, we are setting up the field for a backlash of pessimism about the prospects of long-term recovery and the value of addiction treatment as a social institution [23].

'Addiction treatment is a godsend for hundreds of thousands of individuals and families, but its role in the recovery process is misrepresented to the public through the slogan "Treatment Works".'

FUTURE OF THE FIELD

A: You have warned of a coming leadership crisis in the addictions field. Describe the nature of that crisis and what we need to do to prepare for it.
WLW: First let me say this is not the first time we have faced such a crisis. There were many things that led to the demise of the network of inebriate homes, inebriate asylums and private addiction cure institutes that

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flourished in the United States in the late 19th century. The field in this earlier era suffered from a weak scientific foundation, ideological and territorial schisms, ethical abuses, unexpected economic depressions and a rise in cultural pessimism about the prospects of addiction recovery. But in a very real sense, the field died of old age. The pioneers who had birthed and nurtured addiction treatment into professional maturity over several decades failed to deal with the problem of leadership development and leadership succession. When threats coalesced in the early 20th century to threaten the field's character and existence, no new generation of leaders was prepared to meet this challenge [8]. We are potentially in the same position. Long-tenured leaders of the addiction treatment field—policy makers, researchers, administrators, clinical directors and clinicians, trainers, journal editors, direct service providers—are poised to leave the field en masse in the next decade at a time when the probationary status of addiction treatment as a social institution is again being questioned. We have a short window of time for leadership development and succession planning. We also need to create the infrastructure to repopulate the field with a new generation of front-line workers. I have been challenging all my long-tenured peers that we cannot leave this field until we have identified and trained our replacements and found ways to leave lasting legacies of our work in this field.

A: What is your greatest fear about the future of the field?
WLW: Tom McGovern and I recently made some predictions about the future of the field with full awareness that most people who make such predictions make fools of themselves [24]. My fear is that the field of addiction treatment will disappear while an illusion of its continued presence remains. This would most probably happen by the field being colonized by more powerful forces in its operating environment—a kind of death by absorption. This happened at a micro level in the 1990s, when large numbers of hospital-based addiction treatment units collapsed or were absorbed into hospital psychiatric units. In the latter cases, the hospitals continued to market the availability of addiction treatment services that, for all practical purposes, no longer existed. When I visited many of those units in the years following these mergers I found little core technology of addiction treatment, only veneer-thin knowledge of the recovery process and non-existent relationships with local communities of recovery. I worry that this could happen at a more global level—that addiction treatment could be absorbed by psychiatry or become an appendage of the criminal justice system while losing the unique contributions the field has offered individuals and families suffering from addiction.

A: What are those qualities that you think historically distinguish the specialized field of addiction treatment from all the other social institutions and roles that interact with people with severe alcohol and other drug problems?
WLW: That is the question upon which the field's cultural legitimacy and fate rest. I do not think there is one thing that distinguishes us but, even with all of our internal debates, there are foundational premises of addiction treatment that distinguish us from other helping institutions. The most important of these is that severe alcohol and other drug problems are primary problems that require direct treatment. We do not believe, as allied professionals often have, that addiction is a superficial symptom of other problems and that addiction will dissipate spontaneously when the 'real' problems are resolved. We believe that severe AOD problems are best resolved with assistance from those who have a deep understanding of addiction and recovery processes. We believe that these problems are best resolved in a service relationship free of contempt and that rests upon a foundation of moral equality and emotional authenticity. We contend that there are specific technologies of recovery initiation and maintenance within the addiction treatment field that are not available from other helping professionals and institutions. And we have a unique historical relationship between specialized addiction treatment and community-based recovery mutual aid societies. All manner of helping institutions and helping professions have sought to repair or respond to the consequences of addiction, but only the addiction field has focused on the morbid appetite that is the primal source of such consequences.

A: What would you consider your most significant achievement in the field?
WLW: The weak infrastructure of the field—the continued transience of the field's organizations and workforce—make it difficult for anyone to craft a lasting legacy. In the years I worked as a national trainer, it became evident to me that the faces of the field were constantly changing and that I could never reach enough people face to face to leave a lasting mark on the field. It was at that point that I committed myself to creating a body of work in writing and to find young people with a deep commitment to the field whom I could mentor and who could carry my work into the future. If I leave a legacy, it will be in my writings and in how I have helped shape the character and skills of the field's next generation of front-line clinicians and recovery advocates. I feel I have given the treatment field in the United States the gift of its history, and I hope *Slaying the Dragon* will stir similar efforts to capture the history of addiction treatment in other countries.

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A: In closing, how have you kept such passion for this work over the past four decades?

WLW: I have watched closely those people who have made sustained contributions in this field and sustained their health through that process. I have tried to model my professional life on what I have learned from them. I found four things in the lives of these professional elders: centering rituals that helped them continually refine their goals and evaluate their progress, replenishment rituals that allowed them to interact with others who shared their aspirational values, a commitment to self-development and self-care of themselves and their families and involvement in unpaid acts of service to others. I have pursued these strategies imperfectly, but I suspect they are the source of my professional resilience. This is a field whose front lines can consume you through the losses you experience, but it is also a field that can reward you at the deepest levels. I do not know any other helping arena within which you can witness people completely transform their lives. We get to participate in people redefining who they are at a most fundamental level, some of whom go on to lives of remarkable achievement and service to others. Staying attuned to the reality of such transformations and the potential for such transformations in all those we serve is a well of replenishment from which we should all regularly drink.

'This is a field whose front lines can consume you through the losses you experience, but it is also a field that can reward you at the deepest levels. I do not know any other helping arena within which you can witness people completely transform their lives.'

A: What fills your life outside of your professional activities?

WLW: Very simple pleasures: love for my wife and children, work in my private garden, long walks through the lush foliage and beaches near our Florida home, constant reading and donating time to grass-roots recovery advocacy groups. I have traveled so much through my work that travel has rarely been a source of relaxation and pleasure for me. I am now phasing-down my professional travel, and my wife and I are looking forward to increasing our visits to other countries.

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This article will be part of *Perspectives on Peer-based Recovery Support Services*, the third in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

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The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives

White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

Ethical Guidelines for the Delivery of Peer-based Recovery Support Services

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With a discussion of legal issues by Renée Popovits and Elizabeth Donohue

Prepared for the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS)

and

Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT)

INTRODUCTION

There is a long history of peer-based recovery support services within the alcohol and other drug problems arena, and the opening of the twenty-first century is witnessing a rebirth of such services (White, 2004a). These services are embedded in new social institutions such as

recovery advocacy organizations and recovery support centers and in new paid and volunteer service roles. These peer-based recovery support roles go by various titles: recovery coaches, recovery mentors, personal recovery assistants, recovery support specialists, and peer specialists. Complex ethical and legal issues are arising within the performance of these roles, issues for which little guidance can be found within the existing literature.

The twin purposes of this article are 1) to draw upon the collective experience of organizations that are providing peer-based recovery support services to identify ethical issues arising within this service arena, and 2) to offer guidance on how these issues can best be handled. Toward that end, we will:

- define the core responsibility of the peer recovery support specialist (here referred to generically as *recovery coach*);
- provide an opening discussion of key ethical concepts;
- outline a model of ethical decision making that can be used by recovery coaches and those who supervise them;
- discuss vignettes of ethical situations that can arise for recovery coaches related to personal conduct, conduct in service relationships, conduct in relationships with local service professionals and agencies, and conduct in service relationships with the larger community; and
- provide a sample statement of ethical principles and guidelines for recovery coaches.

An appended paper also identifies the extent to which current laws governing roles in addiction treatment (e.g., confidentiality, duty to warn, personal/organizational liability) are applicable to recovery coaches and their organizations.

We have two intended audiences for these discussions: individuals who are in positions of responsibility for the planning, implementation, and supervision of peer-based recovery support services and individuals who are working in either paid or volunteer roles as recovery coaches. This paper is designed to be adapted for use in the training of recovery coaches and their supervisors. The paper will remain in the public domain and may be adapted as a training aid or used without request by other recovery support organizations as a reading resource. We encourage the use of the decision-making model and the ethical case studies in the paper in the orientation and training of recovery coaches.

PEER-BASED RECOVERY SUPPORT ROLES AND FUNCTIONS[1]

Recovery support services, as the term is used here, refers to non-clinical services that are designed to help initiate and sustain individual/family recovery from severe alcohol and other drug problems and to enhance the quality of individual/family recovery. The Center for Substance Abuse Treatment's Recovery Community Support Program identified four types of recovery support services:

[1] This section excerpts material from White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor, 5*(6), 20-22.

- ***Emotional support****—demonstrations of empathy, love, caring, and concern in such activities as peer mentoring and recovery coaching, as well as in recovery support groups*
- ***Informational support****—provision of health and wellness information; educational assistance; and help in acquiring new skills, ranging from life skills to skills in employment readiness and citizenship restoration*
- ***Instrumental support****—concrete assistance in task accomplishment, especially with stressful or unpleasant tasks such as filling out applications and obtaining entitlements, providing child care, or providing transportation to support-group meetings and clothing assistance outlets (clothing closets).*
- ***Companionship****—helping people in early recovery feel connected and enjoy being with others, especially in recreational activities in alcohol- and drug-free environments*. This assistance is particularly crucial in early recovery, when little about abstaining from alcohol or drugs is reinforcing.

  (Source: http://rcsp.samhsa.gov/about/framework.htm)

Some of the service activities now provided within the rubric of recovery support services include activities performed in earlier decades by people working as outreach workers, case managers, counselor assistants, and volunteers. Recovery support services may be provided by clinically trained professionals as an adjunct to their clinical (assessment and counseling) activities, or they may be delivered by people in recovery who are not clinically trained but who are trained and supervised to provide such support services. They are being provided as adjuncts to other service roles or within specialty roles. Recovery support services are being provided by people working in full- and part-time paid roles and by people who provide these services as volunteers.

Peer-based recovery support roles are growing rapidly in the mental health and addiction service arenas. While there are specific issues related to peer-based services that are distinct within these two fields, the fields have much they can learn from each other.[2]

Part of what makes the ethical delivery of recovery support services so challenging in the addictions context is that the recovery coach performs so many roles. In service organizations piloting this role, the recovery coach is being described as a(n):

- Outreach worker (identifies and engages hard-to-reach individuals, offers living proof of transformative power of recovery, makes recovery attractive)
- Motivator and cheerleader (exhibits faith in capacity for change, encourages and celebrates recovery achievements, mobilizes internal and external recovery resources, encourages self-advocacy and economic self-sufficiency)
- Ally and confidant (genuinely cares and listens, can be trusted with confidences)
- Truth-teller (provides feedback on recovery progress)

[2] Particularly recommended are the following three resources from the mental health field: 1) Mowbray, C.T., Moxley, D.P., Jasper, C.A., & Howell, L.A. (Eds.) (1997). *Consumers as providers in psychiatric rehabilitation.* Columbia, MD: International Association of Rehabilitation Services; 2) Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2005). *Recovery from severe mental illness: Research evidence and implications for practice.* Boston: Center for Psychiatric Rehabilitation; and 3) Spaniol. L., Gagne, C., & Koehler, M. (Eds.) (1997). *Psychological and social aspects of psychiatric rehabilitation.* Boston: Center for Psychiatric Rehabilitation.

- Role model and mentor (offers his/her life as living proof of the transformative power of recovery, provides stage-appropriate recovery education)
- Planner (facilitates the transition from a professionally directed treatment plan to a consumer-developed and consumer-directed personal recovery plan)
- Problem solver (helps resolve personal and environmental obstacles to recovery)
- Resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support; matches individuals to particular support groups/meetings)
- Monitor (processes each client's response to professional services and mutual-aid exposure, to enhance service/support engagement, reduce attrition, resolve problems in the service/support relationship, and facilitate development of a long-term, sobriety-based support network; provides periodic face-to-face, telephonic, or email-based monitoring of recovery stability and, when needed, provides early re-intervention and recovery re-initiation services)
- Tour guide (introduces newcomers into the local culture of recovery; provides an orientation to recovery roles, rules, rituals, language, and etiquette; opens opportunities for broader community participation)
- Advocate (helps individuals and families navigate complex service systems)
- Educator (provides each client with normative information about the stages of recovery; informs professional helpers, the community, and potential service consumers about the prevalence, pathways, and styles of long-term recovery)
- Community organizer (helps develop and expand available recovery support resources, enhances cooperative relationships between professional service organizations and indigenous recovery support groups, cultivates opportunities for people in recovery to participate in volunteerism and other acts of service to the community)
- Lifestyle consultant/guide (assists individuals/families in developing sobriety-based rituals of daily living, encourages activities (across religious, spiritual, and secular) frameworks that enhance life meaning and purpose)
- Friend (provides sober companionship, a social bridge from the culture of addiction to the culture of recovery) (White, 2004a)

The fact that these functions overlap with other helping roles, including that of the addictions counselor, raises the potential for role ambiguity and conflict. Agencies experimenting with these new roles insist that the recovery coach is NOT a:

- sponsor,
- therapist/counselor,
- nurse/physician, or
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church) (See White, 2006a,c).

Role Boundary Integrity: The RC is NOT a:	**You are moving beyond the boundaries of the recovery coach role if you:**
Sponsor (or equivalent)	• Perform AA/NA or other mutual-aid group service work in your RC role • Guide someone through the steps or principles of a particular recovery program
Therapist/counselor	• Diagnose • Provide counseling or refer to your support activities as "counseling" or "therapy" • Focus on problems/"issues"/trauma as opposed to recovery solutions
Nurse/Physician	• Suggest or express disagreement with medical diagnoses (including psychiatric diagnoses) • Offer medical advice • Make statements about prescribed drugs beyond the boundaries of your training and experience
Priest/Clergy	• Promote a particular religion/church • Interpret religious doctrine • Offer absolution or forgiveness (other than forgiveness for harm done specifically to you) • Provide pastoral counseling

People serving as recovery coaches, rather than being legitimized through traditionally acquired education credentials, draw their legitimacy from *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge is information acquired about addiction recovery through the process of one's own recovery or being with others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others achieve and sustain recovery. Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise are ideal candidates for the role of recovery coach. The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery to those who have offered sustained living proof of their expertise as recovery guides (White & Sanders, 2006). The recovery coach works within a long tradition of wounded healers—individuals who have suffered and survived an illness or experience who use their own vulnerability and the lessons drawn from that process to minister to others seeking to heal from the same condition (White, 2000a,b; Jackson, 2001).

Recovery coaching at its best offers dimensions of recovery support not available from other service roles. We asked individuals from three states (Pennsylvania, Connecticut, and Texas) who had experienced recovery coaches what these recovery coaches contributed to their early recovery experiences. Here are some of their responses.

> *My recovery coach builds me up and makes me feel like I am someone and I can accomplish anything I set my mind to. He provides his experience in recovery and his strength and hope.*

> *Support. It's comfortable to have someone behind me—I don't think I could do it on my own. They always help me to look at things differently*.

My recovery coach is 100% real. She has been there and done that. She understands me and knows where I'm at in this point in my life. She knows exactly what to say and do for me to build me up and keep me strong. It's like we are on the same level and she is here to help me move on and get to the next step in my recovery and in my life.

*He gave me a little self-esteem. He asked me, was I ready? I was able to share my past. He helped place me in the Mentor Plus program. He walked me through. He told me it would not be eas*y.

Recovery coaching has helped me set goals in my life. It has also taught me to be accountable for my actions. The coach didn't really give advice, more like guidance to make better decisions on my own.

She helped me paint a picture that I am not alone, and that there are a lot of recovering addicts out there and they actually have a lot of clean time. I didn't know that before.

I wanted to become a responsible daughter and mother and a respected and productive member of the community. I started doing anything and everything for my recovery. One of the most important things was that I got mentors for the Mentor Plus program. They came to see me every week, eventually twice a week. They gave me direction and were there to support me.

His demeanor of recovery showed me I could get what he has.

Recovery coaches, particularly those serving in this capacity as volunteers, are also quite explicit in what they get out of this service process.

I like working with people and being able to offer encouragement and support. It's very rewarding to see people start getting their lives back. Sometimes I see people who don't make the right choices, and that can be frustrating, because I remember what that was like and I feel for them. It helps me to remain grateful for how much better my life is now that I'm in recovery, and I try to pass that message on to them. I am a part of a wonderful process, and helping others helps me more than I can say.

In helping individuals build and rebuild recovery capital, I have learned, not only a lot about these people, but a lot about myself.

Today I know that I don't know. In letting someone in on that secret, it reassures them that it is okay not to be all knowing and all powerful.

In being a recovery coach, I am able to make a small dent in the world around me and a huge change in my own life.

Personally, I love what I do. I have been helping people in recovery since the beginning of my recovery in 1989. I have been blessed to have such a great appreciation for helping others that it has become a part of me. There is no greater feeling than to help someone out of the gutter where I came from and see them grow.

I feel I am giving back by helping assist others in their recovery process. By practicing what I preach, I am able to build and nurture areas of spiritual growth in my life. I am

able to maintain a sense of integrity and character. Working as a recovery coach has helped me evaluate strengths and weaknesses and improve my listening skills. I feel trusted and valued as a mentor when people allow me to help them reach their goals. I feel special.

When that 'light' comes on, it is so exciting to witness. I do recovery coaching for selfish reasons…I'm looking for more 'light.'

Recovery coaching is in its frontier stage. The role is being defined differently around the country based on the unique needs of particular communities and particular client populations. That variability is both a source of strength (responsiveness to the particular needs of individuals, families, and communities) and a source of vulnerability (the lack of consistent role definition and prerequisites). Orientation, training, and supervision protocols for recovery coaches are in an early stage of development.

The excitement about the recovery coach's role is tempered by concerns about potential conflicts with other service roles, and concerns about harm that might come to recipients of recovery support services due to incompetence or personal impairment on the part of the recovery coach—concerns that apply to all health and human service roles. There are several characteristics of recovery support services that influence the vulnerability of consumers and providers of peer-based recovery support services.

First, recovery support needs span the periods of pre-recovery engagement, recovery initiation, recovery stabilization, and recovery maintenance. As such, these service relationships last far longer than the counseling relationships that are the core of addiction treatment, are far more likely to be delivered in the client's natural environment, and often involve a larger cluster of family and community relationships.

Second, recovery support relationships are less hierarchical (less differential in terms of power and vulnerability) than the counselor-client relationship, involve different core functions, and are governed by different accountabilities. Given these factors, the ethical guidelines that govern the addiction counselor are often not applicable to the recovery coach. Efforts to impose ethical standards from traditional helping professions might inadvertently lead to the over-professionalization and commercialization of the role of recovery coach and recreate the very conditions that created the need for peer-based recovery support services. Ethical guidelines for recovery coaches must flow directly from the needs of those seeking recovery and from the values of local communities of recovery.

Third, individual consumers of peer-based recovery support services differ in the kind of non-clinical support services they need, and it is not uncommon for the same person to need different types of support services at different stages of his or her addiction and recovery careers. This requires considerable care in evaluating support service needs, delivering those services within the boundaries of one's knowledge and experience, and knowing how and when to involve people in other service roles.

Fourth, peer-based recovery support services can constitute an adjunct to addiction treatment (for those with high problem severity and low recovery capital) or an alternative to addiction treatment (for those with low or moderate problem severity and moderate or high recovery capital). This requires considerable vigilance in determining service needs and providing services only within the boundaries of one's competence, and skill in making necessary referrals in a timely manner.

All of these conditions underscore the need for a clear set of ethical values and standards to guide the delivery of peer-based recovery support services.

ETHICS: A BRIEF PRIMER

The topic of ethics may be a relatively new one for recovery coaches who have never worked within or received services from an addiction-related service agency. Before proceeding to a discussion of how best to make decisions in the face of ethical dilemmas, we must further enhance our understanding of what we mean when we say that an action of a recovery coach is ethical or unethical. At its most primitive level, aspiring to be ethical involves sustained vigilance in preventing harm and injury to those to whom we have pledged our loyalty. This meaning is revealed through four terms: *Iatrogenic, Fiduciary, Boundary Management,* and *Multi-party Vulnerability*.

Iatrogenic means unintended, treatment-caused harm or injury. It means that an action taken to help someone, possibly with the best of intentions, actually resulted in injury or death. Can you think of an example of such an action? There is a long history of such insults in the history of addiction treatment, e.g., mandatory sterilizations, withdrawal using chemo- and electroconvulsive shock therapies, psychosurgery (e.g., lobotomies), and all manner of drug insults (e.g., treating morphine addiction with cocaine). It is easy today to look back on such "treatments" and wonder "What were they thinking?!" And yet history tells us that it is hard to see such potential injuries close-up. Given the new frontier of recovery coaching, we must be vigilant to quickly weed out well intended actions that harm one or more parties. This potential for harm also underscores the importance of seeking guidance from other recovery coaches and from supervisors.

Fiduciary—a word whose roots are linked to those of the word "faith"—describes relationships in which one person has assumed a special duty and obligation for the care of another. This word is a reminder that the relationship between the recovery coach and those to whom he or she provides services is not a relationship of equal power: It is not solely a supportive friendship. "Fiduciary" implies that one person in this relationship enters with increased vulnerability requiring the objectivity, support, and protection of the other—like a relationship we would have with our own physician or attorney. While the power differential between the recovery coach and those whom he or she coaches is less than that between a surgeon and his or her patient, the recovery coach can still do injury through what he or she does or fails to do. And so these relationships are held to a higher level of obligation and duty than would be friendships that are reciprocal in nature.

Boundary Management encompasses the decisions that increase or decrease intimacy within a relationship. This is an area of potentially considerable conflict between recovery support specialists and traditional service professionals. Where traditional helping professions (physicians, nurses, psychologists, social workers, addiction counselors) emphasize hierarchical boundaries and maintaining detachment and distance in the service relationship, peer-based services rely on reciprocity and minimizing social distance between the helper and those being helped (Mowbray, 1997). While addiction professionals and peer-based recovery support specialists both affirm boundaries of inappropriateness, they may differ considerably in where such boundaries should be drawn.

We might view the relationship between recovery coaches and those they serve upon an intimacy continuum, with a zone of safety in which actions are always okay, a zone of vulnerability in which actions are sometimes okay and sometimes not okay, and a zone of abuse in which actions are never okay. The zone of abuse involves behaviors that mark too little or too great a degree of involvement with those we serve. Examples of behaviors across these zones are listed in the chart below. Place a checkmark for each behavior based on whether you think this action as a recovery coach would be always okay, sometimes okay but sometimes not okay, or never okay.

Table 1: Recovery Coaching: An Intimacy Continuum

Behavior of Recovery Coach in Recovery Support Relationship	Zone of Safety (Always Okay)	Zone of Vulnerability (Sometimes okay; Sometimes not okay)	Zone of Abuse (Never Okay)
Giving a gift			
Accepting a gift			
Lending money			
Borrowing or accepting money			
Giving a hug			
"You're a very special person"			
"You're a very special person to me."			
Invitation to a holiday dinner			
Sexual relationship			
Sexual relationship with a mentee's family member			
Giving your cell phone number			
Using profanity			
Using drug culture slang			
"I'm going through a rough divorce myself right now."			
"You're very attractive."			
Addressing the person by his/her first name			
Attending a recovery support meeting together			
Hiring the person to do work at your home.			

Ethical issues that can arise in situations like those listed above will be explored later in this paper.

Multi-party Vulnerability is a phrase that conveys how multiple parties can be injured by what a recovery coach does or fails to do. These parties include the person receiving recovery support services, that person's family and intimate social network, the recovery coach, the organization for which the recovery coach is working, the recovery support services field, the larger community of recovering people, and the community at large.

It is easy for organizations providing recovery support services to make assumptions about ethical behavior and misbehavior that turn out to be disastrously wrong. Let's consider five such assumptions to open our discussion.

Assumption 1: *People who have a long and, by all appearances, high-quality sobriety can be counted on to act ethically as recovery coaches*.
Fact: Recovery, no matter how long and how strong, is not perfection. We are all vulnerable to isolated errors in judgment, particularly when we find ourselves isolated in situations unlike any we have faced before.

Assumption 2: *People hired as recovery coaches will have common sense.*
Fact: "Common sense" means that people share a body of historically shared experience that would allow a reasonable prediction of what they would do in a particular situation. The diversity of cultural backgrounds and life experiences of people working as recovery coaches provides no such common foundation, and behavior that is common sense in one cultural context might constitute an ethical breach in another.

Assumption 3: *Breaches in ethical conduct are made by bad people. If we hire good people, we should be okay.*
Fact: Most breaches in ethical conduct within the health and human service arena are made by good people who often didn't even know they were in territory that required ethical decision making. Protecting recipients of recovery support services requires far more than excluding and extruding "bad people." It requires heightening the ethical sensitivities and ethical decision-making abilities of good people.

Assumption 4: *Adhering to existing laws and regulations will ensure a high level of ethical conduct.*
Fact: The problem with this assumption is that what is legal and what is ethical do not always coincide. There are many breaches of ethical conduct about which the law is silent, and there might even be extreme situations in which to do what is legally mandated would constitute a breach of ethical conduct resulting in harm or injury to the service recipient. It is important to look at issues of law, but we must avoid reducing the question, "Is it ethical?" to the question, "Is it legal?"

Assumption 5: *Ethical standards governing clinical roles (e.g., psychiatrists, psychologists, social workers, nurses, addiction counselors) can be indiscriminately applied to the role of recovery coach.*
Fact: There are considerable areas of overlap between ethical guidelines for various helping roles, but ethical standards governing clinical work do not uniformly apply to the RC role. This potential incongruence is due primarily to the nature of the RC service relationship (e.g., less hierarchical, more sustained, broader in its focus on non-clinical recovery support service needs) and to its delivery in a broader range of service delivery sites.

Assumption 6: *Formal ethical guidelines are needed for recovery coaches in full-time paid roles but are not needed for recovery coaches who work as volunteers for only a few hours each week.*
Fact: Potential breaches in ethical conduct in the RC role span both paid and voluntary roles. The question recovery support organizations are now wrestling with is whether volunteer and paid RCs should be covered by the same or different ethical guidelines.

Assumption 7: *If a recovery coach gets into vulnerable ethical territory, he or she will let us know. If the supervisor isn't hearing anything about ethical issues, everything must be okay.* Fact: Silence is not golden within the ethics arena. There are many things that might contribute to such silence, and all of them are potential problems. The two seen most frequently are the inability of recovery coaches to recognize ethical issues that are arising and their failure to bring those issues up for fear it will reflect negatively on their performance. The latter is a particular problem where supervision is minimal or of a punitive nature. The best recovery coaches regularly bring up ethical issues for consultation and guidance.

CORE RECOVERY VALUES AND ETHICAL CONDUCT

Traditional professional codes of conduct for the helping professions have been heavily influenced by law and have also drawn heavily from medical ethics. In setting forth a model of ethical decision making and ethical guidelines for recovery support specialists, we sought to look, not beyond the recovery community, but within the history of American communities of recovery, from traditional Twelve-Step communities to religious and secular recovery communities. We drew two conclusions from that exercise. First, we noted the importance of group conscience within the history of particular communities of recovery and the likelihood that judgments of behavior would differ across these recovery communities. That suggested to us the importance of establishing a local council of people in recovery representing diverse recovery experiences that could offer collective guidance on ethical issues as they arise. Second, we looked across recovery traditions (religious, spiritual, and secular) and within the collective experience of organizations providing recovery support services and found a set of core values shared across these organizations. We felt that these values could provide a helpful filter for ethical decision making, and that it was important to evaluate actions of the recovery coach by these shared values rather than by the values of any one recovery community. These core values and the obligations we felt they imposed on those providing recovery support services are listed below.

- Gratitude & Service
  —Carry hope to individuals, families, and communities.
- Recovery
  —All service hinges on personal recovery.
- Use of Self
  —Know thyself; Be the face of recovery; Tell your story; Know when to use your story.
- Capability
  —Improve yourself; Give your best.
- Honesty
  —Tell the truth; Separate fact from opinion; When wrong, admit it.
- Authenticity of Voice
  —Accurately represent your recovery experience and the role from which you are speaking.
- Credibility
  —Walk what you talk.
- Fidelity

—Keep your promises.

- Humility
  —Work within the limitations of your experience and role.
- Loyalty
  —Don't give up; Offer multiple chances.
- Hope
  —Offer self and others as living proof; Focus on the positive—strengths, assets, and possibilities, rather than problems and pathology.
- Dignity and Respect
  —Express compassion; Accept imperfection; Honor each person's potential.
- Tolerance
  — "The roads to recovery are many" (Wilson, 1944); Learn about diverse pathways and styles of recovery.
- Autonomy & Choice
  —Recovery is voluntary: It must be chosen; Enhance choices and choice-making.
- Discretion
  —Respect privacy; Don't gossip.
- Protection
  —Do no harm; Do not exploit; Protect yourself; Protect others; Avoid conflicts of interest.
- Advocacy
  —Challenge injustice; Be a voice for the voiceless; Empower others to speak.
- Stewardship
  —Use resources wisely.

A PEER-BASED MODEL OF ETHICAL DECISION MAKING

A model of ethical decision making is simply a guide to sorting through the complexity of a situation and an aid in determining the best course of action that one might take in that situation. We propose that those providing recovery support services ask three questions to guide their decision making (Note: A worksheet on these questions is provided after the article, on Page 31).

Question One: Who has the potential to be harmed in this situation, and how great is the risk for harm? One answers this question by assessing the vulnerability of the parties listed in the table below and determining the potential for, and possible severity of, injury to each. Where multiple parties are at risk of moderate or significant harm, it is best not to make the decision alone, but to seek consultation with others, given the potential repercussions of the situation.

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

Question Two: Are there any core recovery values that apply to this situation, and what course of action would these values suggest be taken?

___ Gratitude & Service (Carry hope to individuals, families, and communities).
___ Recovery (All service hinges on personal recovery).
___ Use of Self (Know thyself; Be the face of recovery; Tell your story).
___ Capability (Improve yourself; Give your best).
___ Honesty (Tell the truth; Separate fact from opinion; When wrong, admit it).
___ Authenticity of Voice (Accurately represent your recovery experience and role).
___ Credibility (Walk what you talk).
___ Fidelity (Keep your promises).
___ Humility (Work within the limitations of your experience and role).
___ Loyalty (Don't give up; Offer multiple chances).
___ Hope (Offer living proof; Focus on the positive).
___ Dignity and Respect (Express compassion; Accept imperfection; Honor potential).
___ Tolerance ("The roads to recovery are many.") (Wilson, 1944)
___ Autonomy & Choice (Recovery is voluntary; it must be chosen).
___ Discretion (Respect privacy; don't gossip).
___ Protection (Do no harm to and protect self and others; Avoid conflicts of interest).
___ Advocacy (Challenge injustice; be a voice for the voiceless; empower others).
___ Stewardship (Use resources wisely).

Question Three: What laws, organizational policies or ethical standards apply to this situation, and what actions would they suggest or dictate?

In the next section, we will explore a wide variety of ethical dilemmas that can arise in the context of delivering recovery support services and illustrate how this three-question model can be used to enhance decision making.

ETHICAL ARENAS

Ethical issues can crop up in a number of arenas related to the delivery of peer-based recovery support services. In this section, we will present and discuss case vignettes to highlight such issues within five arenas: 1) service context, 2) personal conduct of the recovery coach**,** 3) conduct in service relationships, 4) conduct in relationships with other service providers, and 5) conduct in relationships with local recovery communities. The vignettes and discussion were developed in consultation with the PRO-ACT Ethics Workgroup and other organizations delivering recovery support services. The responses to the vignettes are not intended to generate rules for behavior; they are intended to convey the evolving sensitivities on key ethical issues within the growing recovery support services movement.

SERVICE CONTEXT

Exploitation of Service Ethic: Agency ABC visibly promotes itself as providing peer-based recovery support services, but the agency's reputation is being hurt by key practice decisions.

- ABC hires people as recovery coaches who have minimal sobriety time.

  The legitimacy of each RC is derived from experiential knowledge and experiential expertise. Where there is little or no experience, there is no legitimacy. Recovery coaches should be hired only if they have established personal programs of recovery marked by duration and quality. Minimum recovery requirements for recovery coaches are currently ranging from one to two years, with many recovery coaches possessing more than five years of continuous recovery. This minimum requirement is for the protection of those receiving, and for the people and organizations providing, recovery support services.

- ABC does little to orient, train, or supervise their recovery coaches.

  Failure to provide RCs with the needed orientation, training, and supervision affects their capabilities, their credibility, and the safety of both the RC and the person receiving recovery support services. The quality of screening, training, intense initial supervision, and ongoing supervision constitute the foundation for the delivery of effective and ethical recovery support services. The delivery of RC services, particularly volunteer-based RC services, requires more supervision than clinical services provided within an addiction treatment context, because non-clinical recovery support services often lack some of the mechanisms of protection built into the delivery of treatment services, e.g., prolonged training and credentialing, a formal informed consent process, and office-based service delivery. Developing clear policies governing the delivery of recovery support services, and establishing monitoring procedures to oversee the delivery of those services, also can help ensure that the delivery of RC services will be covered within the sponsoring organization's liability/malpractice insurance.

- ABC pays recovery coaches a pittance while asking them to work excessive hours that often interfere with their own recovery support activities.

This practice constitutes a form of financial exploitation of recovering people that contributes to RC burnout, high RC turnover, and erosion in the quality of recovery support services. Providing adequate support for volunteers, paying adequate salaries, offering advancement opportunities for RCs in paid roles, and setting limits on hours worked for both volunteers and paid support specialists are crucial steps in sustaining the quality of peer-based recovery support services.

- ABC assigns volunteer recovery coaches to perform counselor functions, then bills for these services.

  This practice is a breach of ethical principles (honesty & fidelity), a breach of law, and a practice that violates the integrity of both the counselor role and the RC role. RCs are not cost-free labor; substantial expense should be incurred in the infrastructure to support volunteer recovery coaches via recruitment, screening, selection, orientation, ongoing training, ongoing supervision, and events celebrating the service work of RC volunteers.

- ABC assigns recovery coaches to work in isolation, delivering home-based services in drug- and crime-saturated neighborhoods.

  RCs assigned to home-based services, particularly those delivering pre-treatment engagement and support (outreach) services, need elevated supports to counter the particular stressors inherent in this role. Such supports include special training related to safety management, team-based service delivery (co-coaching), technical supports (cell phones, two-way radios), neutral sites for meetings in high-risk neighborhoods, etc.

- ABC uses recovery coaches almost exclusively to recruit clients into treatment.

  This practice, when it involves using the RC role to "fill beds" or outpatient "slots," constitutes an exploitation of the RC role for the financial benefit of the organization. It reflects poor stewardship of the RC resource by displacing the recovery support needs of clients for the financial interests of the organization.

Screening Practices: DEF is a grassroots recovery advocacy organization that provides recovery coaching services through a cadre of volunteers from the recovery community. Today, a man notorious for his predatory targeting of young women entering NA arrives at DEF announcing that he would like to volunteer as a recovery coach. How should DEF respond to this request?

The screening of volunteers and staff for recovery support roles is designed in part to protect the hiring agency and its service constituents. This protection function must be ensured, and at the same time the agency must practice standards of fairness in its selection procedures, e.g., not excluding someone based only on second-hand gossip. Selection for RC roles is unique in that a past addiction-related felony conviction (followed by a long and stable recovery career) might be viewed as more a credential than grounds for disqualification. On the other hand, a history of and reputation for exploitive behavior within the recovery community might be grounds for disqualification. The purpose of such disqualification would be the protection of service recipients and the protection of the reputation of the recovery support organization, e.g., ensuring that people feel safe and comfortable seeking services at the organization. White and Sanders (2006) describe how the credential of experiential expertise is established:

Experiential expertise is granted through the community "wire" or "grapevine" (community story-telling) and bestows credibility that no university can grant. It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships, and performance within the community (White & Sanders, 2006, p. 69).

The community wire can withhold as well as bestow the credential of experiential expertise, and it can grant such expertise with conditions, e.g., using the individual in the above role as a closely supervised RC, but only with men.

PERSONAL/SERVICE CONDUCT

Self-Care: Jerome brings great passion to his role as an RC, but models very poor self-care. He is overweight, smokes excessively, and has chronic health conditions that he does not manage well. To what extent are these ethical issues related to his performance as a recovery coach? What is the nexus between such private behaviors and Jerome's performance as an RC?

Private behavior of the RC is just that—private, UNTIL there is an inextricable nexus (link) between private behavior and one's performance as a RC. In this case, Jerome's poor self-care does potentially impact his effectiveness as a RC. The expectation here is not one of perfection, but one of reasonable congruence between one's espoused values and the life one is living. In this case, Jerome is modeling potentially lethal behaviors that those he coaches may well integrate into their own lifestyles, e.g., "It is okay for me to smoke because Jerome smokes." Part of the job of the RC is to make recovery attractive—to make recovery as contagious as addiction in the local community. To become a recovery coach requires being, not only a face and voice of recovery, but also a person whose character and lifestyle others would choose to emulate. Our ability to achieve that is enhanced by self-care training that is built into the overall RC orientation and training program.

Personal Impairment: Mary has functioned as an exceptional RC for the past two years, but she is currently going through a very difficult divorce. The strain of the divorce has resulted in sleep difficulties, a significant loss of weight, and concern by Mary about the stability of her sobriety and sanity. When do such events in our personal lives become professional practice issues? What should Mary and her supervisor do in response to these circumstances?

Again, events in our personal lives are of concern when, and only when, they ripple into our performance in the service arena. All of us undergo developmental windows of vulnerability that require focused self-care and temporarily diminish our capacities for service to others. Mary and her supervisor need to consider what would be best for her, for those she coaches, and for the agency. One option is for Mary to decrease her hours or number of people served and to have increased supervisory or peer support (e.g., team coaching) for a period of time. Another option would be for Mary to take a sabbatical to focus on getting her own health back in order. For Mary to raise this issue in supervision is not something to be ashamed of, but the mark of service excellence—

making sure that our own periodic difficulties do not spill into the lives of those we are committed to helping.

Lapse: Ricardo, who has worked as an RC for more than a year, experienced a short lapse while attending an out-of-town wedding. Because the lapse was of such short duration, Ricardo plans not to disclose the relapse to the organization through which he provides RC services. What ethical issues does this situation raise? What should Ricardo do? What should be the organization's/supervisor's response if this situation is brought to his or her attention? What organizational policies must be established to address the issue of lapse/relapse?

There are several core values that apply to this situation, e.g., honesty, credibility, primacy of recovery. All of these values suggest a course of action that would begin with Ricardo's disclosure of the lapse to his supervisor and focusing on re-establishing the stability and quality of his personal recovery program. The organization should rigorously follow the guidelines/protocols it has established to respond to such an event. Options might include Ricardo's taking a break from his RC responsibilities, performing activities that do not involve direct coaching responsibilities, and later phasing back into RC responsibilities via co-coaching and more intensive supervision.

Personal Bias: Zia has many assets that would qualify her as an excellent RC, but in interviewing her for an RC position, you are concerned about one potential problem. Zia passionately believes that AA's Twelve Step program is the ONLY viable framework of long-term addiction recovery, and she expresses considerable disdain for alternatives to AA. What ethical issues could arise if Zia brought her biases in this area into her functioning as an RC?

*The core value of tolerance asserts the legitimacy of and respect for diverse pathways and styles of long-term recovery. Bill Wilson (1944) was one of the first advocates of such diversity. If Zia cannot develop such tolerance, she may be better suited to the service role of sponsor within a Twelve Step program than to the role of an RC who works with multiple programs of recovery. The same principle would apply to those using recovery programs other than the Twelve Steps who believe there is only one true way to recovery, or who have antipathy toward one particular program. What we know from research on recovery is that ALL programs of recovery have optimal responders, partial responders, and non-responders (*Morgenstern, Kahler, Frey, & Labouvie, 1996). T*raining and exposure to people in long-term recovery representing diverse recovery pathways can be used to promote tolerance for multiple pathways of recovery.*

Pre-existing Relationships: Barry's supervisor has assigned a new contact for Barry to visit in his RC role. Barry recognizes the name as a person to whom Barry once sold drugs in his earlier addicted life. Who might be harmed in this situation? What should Barry do? Does Barry have a responsibility to report this pre-existing relationship to the supervisor?

Multiple parties may be at risk here: Barry, his contact, the contact's family, and Barry's agency. Barry should disclose the relationship and request another assignment. If the only alternatives are Barry or no services (e.g., a situation in which Barry might be the only recovery coach in the community), Barry and his supervisor should explore additional options or explore how they might ensure that these RC services are provided and still minimize harm to all parties. The most critical factor here is the need to maximize the comfort and safety of the individual/family receiving services. It is best if RCs are expected to declare immediately any pre-existing relationships with those to whom they have been assigned.

Use of Information Across Roles: Rebecca is a natural listener. Everyone talks to her—in her RC role and outside her RC role. Rebecca is also very active in the local Twelve-Step community. Today, a person Rebecca is coaching mentions the name of a new boyfriend whom Rebecca recognizes as a man with whom one of her sponsees is involved. The relationship between the sponsee and this man has been a major source of sabotage to the sponsee's recovery, and the sponsee also contracted an STD from this man. Can Rebecca use information gained from roles in her personal life in her role as an RC? How should she handle this situation?

> *This vignette generated considerable disagreement among the recovery support agency representatives who reviewed it. Opinions split into two camps. The first group suggested that Rebecca could, and had a duty to, disclose this information as long as it was judged to be reliable and as long as no anonymity was violated related to the disclosure. The other camp took the position that disclosing this information would violate AA etiquette ("What's said here, stays here"), that it was not Rebecca's role to disclose this information, and that Rebecca needed to stay supportive through whatever unfolded within this relationship. A good general guideline is: moving information from one role into another role (e.g., using information gained at a Twelve-Step meeting into one's RC activities) is fraught with potential harm and should be brought into supervisory discussion before such information is used in this manner.*

Advocacy: Many RCs are also involved in recovery advocacy activities in their local communities. Are there any situations that might arise in one's advocacy role that could conflict with one's role as an RC? Could any of these situations involve potential harm to others?

> *This would depend on the nature of the recovery advocacy activities. There are many recovery coaches who are also very much involved in the new recovery advocacy movement who experience minimal conflict in these roles. Conflicts could arise if the recovery advocate/coach:*
>
> - *used the RC context to zealously recruit those whom he or she coached into advocacy activities;*
> - *used the RC role to push particular ideological propositions; or*
> - *took such extreme, controversial positions that individuals and families were not comfortable having the individual serve as their RC.*
>
> *Such potential conflicts are best processed with one's supervisor.*

Conflict of Interests: Raphael works as a recovery coach and also owns a recovery home. In his RC role, Raphael frequently encounters people who need sober housing. What ethical issues could arise from Raphael's referral of people to the recovery home that he owns? How might Raphael best handle any real or perceived conflicts of interest? What organizational policies address the issue of conflicts of interest?

> *Referring clients to his own recovery home raises potential conflicts between the client's best interests and Raphael's own financial interests. Even the PERCEPTION of bias relating to this linkage process might injure Raphael's reputation as an RC and the reputation of the organization for which he is working. Raphael would be better advised to refer his clients to other recovery homes or to offer a list of all available resources*

without any accompanying interventions that would direct individuals to his own facility. In addition, Raphael may want to assign a "manager" to do all screening for potential residents to his home, so that he not only doesn't refer his own clients, but also doesn't make decisions related to their entrance. At a minimum, Raphael will want to make sure that those he serves always have a choice of resource options and that he does nothing to steer people toward institutions in which he has a financial interest.

Role Integrity: Marcella is in long-term recovery, works as a volunteer recovery coach, and also works full time as a certified addictions counselor. What problems might be posed by Marcella's bringing the clinical orientation from her counselor role into her volunteer role as a recovery coach? How can the organization/supervisor help "counselors as peers" suspend their clinical orientation while they are functioning in their RC roles?

The potential problems in this situation are numerous. First, if Marcella drifted into her counseling role while performing volunteer service, she would be providing counseling without the client protections and supports built into traditional treatment agencies, e.g., informed consent, legal confidentiality, clinical documentation, clinical supervision, and agency liability insurance. Assuming Marcella's client is still in treatment, the therapy Marcella provides may be counterproductive to the therapy the client is already receiving. And perhaps most important: during the time in which Marcella is doing counseling, the client is not receiving needed recovery support services.

Compassion Fatigue: Elizabeth has volunteered as an RC for the past 2½ years, supporting the recovery processes of individuals with very severe, complex, and long-term substance use disorders. In recent months, she has noticed that she is bringing less energy and enthusiasm to her volunteer work and is dreading seeing some of those with the greatest needs. How should Elizabeth respond to this diminished motivation for recovery coaching?

The danger here is a process of emotional and physical disengagement that could do a great disservice to those in need of recovery support services. Elizabeth is exhibiting signs of burnout, which must be acknowledged and addressed in supervision. Elizabeth may need a break in her coaching activities, might consider reducing her hours, might need to work with people who have lower levels of problem severity for a while, or might want to consider co-coaching for a period of time. It might also be a good time for Elizabeth to refresh her stress-management skills via training or her own personal coaching. Those volunteering as recovery coaches need the option of taking sabbaticals from this service work, but they also have a responsibility to recognize this need early enough to plan an orderly transition or termination process for those with whom they are working. Both precipitous disengagement and a failure to disengage when disengagement is indicated present potentials for harm to those receiving recovery support services.

CONDUCT IN SERVICE RELATIONSHIPS

Choice/Autonomy: Charise works as a recovery coach in a women's program that is known for its assertive—some would say aggressive—style of outreach to women referred from the child welfare system. The women Charise attempts to engage in treatment and recovery support services are very ambivalent in the early stages of engagement—not wanting to see her one day, thrilled to see her the next. The questions are: "When does 'NO' really mean 'No'?" What

is the line between assertive outreach and stalking? How do we reconcile a person's right to choose with the knowledge that volitional will is compromised, if not destroyed, through the process of addiction?

> *The ethical tension here is between the values of autonomy and choice versus paternalism and outright domination. What complicates any resolution of this tension is the fact that we are working with people who by the definition of their illness (addiction) have compromised capacities for free choice, leaving the RC questioning whose free choice they should listen to—Dr. Jekyll's or Mr Hyde's. In short, what do we do with someone who one moment wants recovery and the next minute wants to get high? The answer is that we recognize that addiction is a disease of the will and that recovery involves a progressive rehabilitation of the will. The RC's job—particularly in the outreach function—is to jumpstart motivation for recovery where little exists, and to guide people through the early stages of recovery until they can make choices that support their own best interests. At a practical level, this means that "no" ("I don't want you to contact me anymore") has to be said several times to different people on different days before we give up on someone (for the time being). If after a reasonable period of time, the answer is still "no," then we disengage with the assurance that we will be available in the future if the person should CHOOSE to call us. The proposition that recovery is voluntary means, not only the freedom to choose different pathways of recovery, but also the freedom to choose not to recover.*

Choice/Autonomy: Roberto has been assigned as a recovery coach for Oscar, but four weeks into this process, Oscar requests a change in recovery coaches on the grounds that he is having difficulty relating to Roberto. Do those receiving RC services have the right to select their own recovery coach?

> *Mismatches in the assignment of recovery coaches are inevitable, just as mismatches occur in the assignment of counselors. A match between a recovery coach and someone whom he or she serves may be even more important because of the increased time spent together and the potential duration of the relationship. The occasional mismatch is best acknowledged early and resolved either through alterations in coaching style or through reassignment to a new recovery coach. The affects of recovery coaching result from personal influence, not from any power or authority ascribed to the role. An essential principle of peer-based recovery support services is that those receiving the service ultimately get to define who qualifies as a "peer." Evaluating and resolving potential mismatches is an integral part of good supervision. It is also important that RCs be supported through these situations.*

Emotional Exploitation: John is a highly sought-out RC. He is charismatic and unrelenting in his support activities. As his supervisor, you have one area of concern about John: he is emotionally possessive of those he works with, hypercritical of other service providers who don't live up to his standards, and competitive with the sponsors of those he coaches. Many of those John serves do very well in their recovery, but they seem to see the source of their recovery as John more than a program of recovery. You are troubled that those John works with seem to have developed an excessive emotional dependency in their relationship with him. What ethical issues are raised by this situation?

> *There are several core values that apply to this situation, e.g., humility, respect, tolerance, autonomy, capability. The style described above, by cultivating dependence and emotionally rewarding crises, actually weakens people's future capacity for self-*

sustained recovery. Those served end up feeling progressively better about John, but worse about themselves. Such a style may meet John's needs, but it ill serves those he coaches. Such styles harm clients, overshadow other RCs who may be doing much more effective service work, and often end up harming the community agency's credibility in the long run. A degree of dependence is normal early in the RC relationship, but such dependence is best transferred to the development of a larger and more sustainable sobriety-based support network.

Friendship: Raymond volunteers as a recovery coach for a recovery community organization (a freestanding organization, unaffiliated with any treatment organization, that provides recovery support services). Raymond shares a lot in common with Barry, a person to whom Raymond has been assigned to serve as a recovery coach. Over a period of months, Raymond and Barry have developed quite a friendship and now share some social activities (e.g., fishing) beyond the hours in which Raymond serves as Barry's recovery coach. Are there any ethical issues raised by this friendship?

Friendships may develop within the context of recovery coaching, but there is one thing that distinguishes the recovery coach relationship from other social relationships, and that is the service dimension of that relationship. This means that recovery coaching relationships are not fully reciprocal, whereas friendships are. The RC has pledged that the focus of the RC relationship is on the needs of the person being coached. In that light, ethical problems could arise if: 1) the friendship were initiated by Raymond to meet his needs and not Barry's needs, 2) problems in the friendship interfered with Raymond's ability to provide effective coaching services, or 3) the friendship with Raymond prevented Barry from developing other sobriety-supportive relationships within the recovery community and the larger community. RC relationships will, by definition, be less hierarchical and more reciprocal than will relationships between an addiction counselor and his or her client. It's not that one boundary demarcation is right and the other is wrong; what is important is that boundaries are maintained that are role-appropriate. In other arenas of peer-based services, their effectiveness has been attributed in great part to the lack of professional detachment and distance (Fox & Hilton, 1994). Where a developing friendship is getting in the way of effective RC services, it is the responsibility of the RC to raise this concern with his or her supervisor, and possibly to review this situation with the RC, the supervisor, and the client. One potential option is to assign and transition the client to another RC, to avoid potential problems stemming from the dual relationship.

Sexual Exploitation: You supervise recovery coaches for a local recovery advocacy and support organization. It comes to your attention that Joshua, one of your RCs, is sexually involved with a person to whom he is delivering recovery support services. What are the ethical issues involved in this situation? How would these issues differ depending on: 1) age or degree of impairment of the person receiving services? 2) whether this was a person currently receiving or a person who had previously received recovery support services? 3) the time that had passed since the service relationship was terminated? Would you view this situation differently if the relationship were not with the primary "client" but with a family member or friend who was involved in the service process? Could the recovery coach or the agency face any regulatory or legal liabilities related to this relationship?

The RC service relationship is not a relationship of equal power. The vulnerability of those seeking RC services and the power of the RC role offer situations in which an RC might exploit service relationships for his or her personal, emotional, sexual, or financial

gain. It is that power discrepancy that makes intimate relationships between RCs and those with whom they work with ethically inappropriate. The harm that can come from such relationships spans injury to the person/family being served (emotional trauma, severance of services, resistance to seeking future services), injury to the reputation of the RC, and damage to the reputation and financial solvency of the service organization (via litigation against the organization for improper hiring, training, supervision, etc.). The prohibition against an intimate relationship between an RC and service recipient also extends to members of the service recipient's family and intimate social network who are involved in the service process. As for relationships with people who previously received RC services, agencies are defining a period of time (mostly in the two-year range) in which such relationships would still be improper. The key here is to evaluate situations that might arise based on the issue of exploitive intent. For example, an RC might be involved with an individual he or she met within the recovery community who he or she discovers once received RC services from the RC's organization. The RC did not work at the organization at the time, never served as the person's RC, had no knowledge of the person's status as a service recipient, and did not use the influence of his or her RC role and organizational affiliation to initiate the intimate relationship. In short, there was no exploitive intent.

Financial Exploitation: Alisha is providing RC services to a very socially prominent and wealthy individual and his family. She has repeatedly turned down the family's offers of money for her services and communicated that her services are provided through a federal grant and are available to all local citizens without charge. It has casually come up in conversations that Alisha is saving money to begin taking courses at the local community college. When Alisha arrives for her visit today, the family announces that they have discussed it among themselves and that they want to pay Alisha's tuition to return to college. What should Alisha consider in her response to this offer?

Money changes relationships. Accepting this gracious offer would threaten the integrity of the coaching relationship. Alisha should express her appreciation for the family's offer, but explain that she must decline because acceptance of this gift while the recovery coaching is in process could affect that relationship. The family's feelings can be further protected if Alisha can inform them that there is an agency policy that prevents any RC from accepting any gifts of substantial value. The situation might be viewed differently if some time after the service relationship was ended, the same family wanted to donate money to Alisha's education or to the service organization. The key here is that the vulnerability or gratitude of the family is not used in an exploitive manner. All offers of gifts to an RC during or following a service relationship should be discussed with the supervisor.

Gifts: Marie works as an RC in an addiction treatment unit within a local community hospital. Her job is to provide recovery support services to those discharged from addiction treatment. She serves a predominately Native American population and conducts most of her work via home visits on two reservations. When she arrives for one of her visits today, the family she is visiting presents her with an elaborate, culturally appropriate gift as a token of their appreciation for her support. The problem is that Marie works in a hospital whose personnel code prohibits any staff member from accepting a personal gift. Marie is concerned about the consequences of accepting the gift, but is also concerned that refusal of the gift could harm her relationship with the family and the tribe. What are the ethical issues here? What should Marie do?

Ethical decision-making must be culturally grounded. What this means is that the pros and cons of any action must be evaluated in the cultural context in which it occurs. What might be unethical in one cultural context (e.g., accepting a gift) might in another be, not only ethical, but also essential in maintaining the service relationship. In this case, Mary could accept the gift in the name of the hospital, protecting herself from the hospital policy and leaving the RC relationship intact. Mary could report the gift to her supervisor and display the gift in a common area of the hospital for all to enjoy. What would be equally appropriate would be for Mary to raise the broader issue of the need for more flexible interpretations of this particular policy when working in this tribal context. Ironically, a policy designed to protect patients might actually result in injury to patients, severance of the service relationship, and damage to the reputation of the service institution. RCs working across cultural contexts need policy flexibility and good supervision to protect the service relationship.

Boundaries of Competence: During a visit today with Camella, a person you are coaching, she asks you what you think about the effects of anti-depressant medications on recovery from alcoholism. She is clearly ambivalent about the medication she is being prescribed, and your first inclination is to tell her to forget the medication and get to more meetings. What are the ethical issues in this situation? How would you respond?

It is quite appropriate for the RC to listen to Camella's concerns about her medication, encourage her to talk to her physician about these concerns, and link her to resources to get additional information about recovery and anti-depressant medications. It is not appropriate for the RC to offer his or her opinion or advice about any prescribed medication. To do so would be to move beyond the boundaries of the RC's education, training, and experience. Even if the RC were a physician volunteer, his or her responsibility in the RC role would be to link Camella to medical resources she could consult about this question, rather than to provide that information directly. Under no circumstance should an RC ever advise anyone to stop taking a prescribed medication. If the RC has concerns about the effects of particular medications on Camella's recovery (e.g., prescribed sedatives or narcotic analgesics), the RC's role is to link Camella to someone with expertise, e.g., a physician trained in addiction medicine, to discuss these issues.

When to Refer: Martha has attempted to engage Rita in the recovery coaching process for the past five weeks, but the chemistry between the two of them seems to have gone from bad to worse. All efforts to work through these difficulties in supervision have failed to improve the situation. At what point should Martha acknowledge this situation to her supervisor and Rita and seek to have another recovery coach assigned to Rita?

The value of honesty dictates that Martha acknowledge to Rita and to Martha's supervisor her concerns about the relationship difficulties, and that she raise the question of whether or not Rita would be better served with a new RC. She should raise this question with the supervisor, and if efforts to improve the relationship fail, then a meeting between Martha, Rita, and the supervisor may be in order. The agenda is to avoid harm to Rita from a relationship mismatch, to establish an effective coaching relationship, but to also avoid any feelings of abandonment that Rita might experience by the suggestion of a new RC.

Discretion: Maria serves as an RC for women and their families who are participating in a local women's treatment program. Maria frequently hears from those she coaches, "I want to tell you

something, but you can't tell my family" or "I want to tell you something important about Jennifer, but I don't want you to tell her I told you." What ethical issues are raised when the RC is placed in the middle of these types of communications? How should Maria handle such communications?

> *It is essential to establish communication ground-rules at the beginning of the RC relationship. The values of discretion, respect, and fidelity demand that the RC not disclose information beyond the established ground-rules. Those ground-rules include review of circumstances in which disclosures will be made, e.g., supervision, medical emergencies, or imminent threat of harm to self or others. Before deciding whether or not to agree to the requested promises described above, Maria should again review those communication ground-rules and the disclosure exceptions.*

Discretion versus Duty to Report: A person for whom you are serving as recovery coach discloses to you that he has been using during the past week with another person who lives with him in a local recovery home. The disclosure makes it clear that the other person provides the drugs used and may be dealing in the home and in the larger community. Further complicating the situation is the fact that the owner of the recovery home is a member of your board of directors. Do you have an ethical responsibility to protect this disclosure or to report the content of the disclosure to the house manager or the owner of the recovery home? Would a recovery coach have a similar obligation to report the presence of a "script doctor" who was pumping massive quantities of prescription opiates into the community—when the source of that information was one of those he or she was coaching?

> *Such information could not be ethically reported without permission for such disclosure. In both cases, the RC could discuss with the disclosing individual whether or not that individual thought the information should be conveyed to responsible authorities, if the individual was comfortable making such a report, or if he or she would want the RC to make such a report without disclosing his or her identity as the source. Using this process would address the threat to the recovery home environment or the community without violating the promise of confidentiality.*

Threat to Community: When you arrive for a home visit with Joe Martin, a person you are coaching, you find him intoxicated. Joe says he can't talk to you right now because he has to return to the bar he just left to pay off a debt. Joe has his car keys in his hand. What do you do?

> *Use all of your persuasion skills to keep Joe out of the car. Ask Joe to give you the car keys, and let him know that, if he gets in the car, you will have no recourse but to call the police. If he gets in his car and drives away, call the police, informing them that you observed an intoxicated man by the name of Joe Martin getting into a car, and provide the vehicle description and location. Do not identify yourself in your service role, and do not identify Joe as a service recipient of the organization. The challenge here is to address the threat to public safety without disclosing Joe's status as a service recipient.*

Personal Bias: Fred has worked hard to educate himself about medication-assisted recovery since he was first hired as an RC, but he still has very negative feelings about methadone in spite of the research literature he has read about it. It's not a "head thing"; it's a "gut thing." Marcy, another RC, has similarly negative feelings about explicitly religious pathways of recovery because of the number of people she has known in AA for whom religion alone did not work as a framework for recovery. Describe how the personal biases of the RC might result in

harm or injury to multiple parties, and how that harm might be avoided. For example, how might Fred separate the scientific facts about methadone from his feelings (opinions) about methadone?

> *As individuals, we may have all manner of biases about different addiction treatments, but in the RC role, we have a responsibility to outline the choices available to those we serve as objectively as possible and support each person's choice of the option that seems best for him or her at this moment. Discouragement of a particular method of treatment may prevent a client from getting the "one" treatment method that might be most successful. Fred and Mary should continue to acknowledge and discuss their biases with their supervisor. Fred and Mary may not need more information and training on alternative treatments and pathways to recovery as much as they need direct contact with people who have successfully used these methods to achieve long-term recovery. As experiential learners, many RCs won't credit the research findings until they experience this evidence face-to-face.*

CONDUCT IN RELATIONSHIPS WITH OTHER SERVICE PROVIDERS

Responding to Unethical Conduct: Susan, a person for whom you have been serving as an RC for the past month, discloses to you today that she is in a sexual relationship with the counselor she is seeing at a local addiction treatment agency. The counselor is a very prominent person in the local recovery community and is very active in the state addiction counseling association. What ethical issues does this situation present? How would you respond?

> *This situation raises several needs. The first is to acknowledge to Susan that such a relationship is a breach of the counselor's professional ethics, and to ask if she wants a referral to a different treatment agency, and if she wants to file a formal complaint with the state counselor certification board or seek other legal redress. Linking Susan to such resources would be a natural RC function, as would supporting Susan through this process. Depending on the policies of your agency, you may also let Susan know that you will need to report this disclosure to your supervisor, who may also be bound to report it to the state certification board, either with Susan's name or without it. All reports of ethical breaches by other service professionals in the community that come to the RC's attention should be communicated to the RC's supervisor.*

Representation of Credentials (Example 1): Samuel works as a recovery coach, doing post-treatment telephone monitoring. In his interactions with the larger community, Samuel has represented that he is working as a "counselor." He also makes periodic mention of his plans to "get back" to graduate school," but Samuel has only completed two years of college and has not been in school for more than ten years. What ethical issues does this situation raise?

> *The values of honesty and credibility call upon the RC to accurately represent his or her education, training, and experience. The supervisor should acknowledge that he or she has heard the above reports and emphasize why it is important that, if the reports are true, these communications stop and be replaced with an accurate description of Samuel's role and educational credentials. This might well be accompanied by a broader discussion of how RCs establish credibility and legitimacy within the larger service community.*

Representation of Credentials (Example 2): Would you view Samuel's situation any differently if he accurately represented his role and education, but misrepresented the length of his own recovery and his degree of current involvement in AA, NA, or another recovery mutual aid group?

> *No, both would undermine his capability and credibility as an RC. The value of authenticity of voice is paramount here. The following guideline is recommended: "Filter decisions related to disclosure of your ATOD use history, your recovery status, and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth); discretion (protect your privacy); and, for those in Twelve Step recovery, the tradition of anonymity at the level of press" (White, 2006b).*

Role Clarity/Integrity: George has worked as Larry's RC for the past two months. Today, Larry asks George if George would be his NA sponsor. George has a long history in NA and a long history of sponsorship activities, but agreeing to this arrangement would mean that he would be both Larry's RC and his sponsor. What harm and injury (if any) might result from such a dual relationship, and who might be harmed?

> *Failure to maintain boundary separation between the roles of RC and sponsor might harm Larry, George, others receiving RC services, the relationship between George's organization and the local recovery community, and the larger community. The effect of dual relationships is often to "water down" both relationships. Here are some suggested operating principles (Excerpted from White, 2006c).*
>
> 1. *Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) on time in which one is working as an RC is a violation of Twelve-Step Traditions and professionally inappropriate (beyond the scope of most agencies' RC job descriptions and explicitly prohibited in many).*
> 2. *Performing sponsorship functions through the RC role could weaken local sponsorship practices and diminish community recovery support resources, by replacing such natural support with the formal support of local treatment agencies.*
> 3. *Seeking reimbursement for sponsorship functions performed by a recovery coach is, at best, a poor stewardship of community resources and, at worst, fraud.*
> 4. *Role ambiguity and conflict resulting from the mixing of sponsorship and RC functions might inflict injury on clients/families, service workers, service agencies, and the community.*
> 5. *The RC role represents a form of connective tissue between professional systems of care and indigenous communities of recovery, and between professional helpers and sponsors. When those filling this role abandon this middle ground and move too far in one direction or the other, that connecting function is lost.*

CONDUCT IN RELATIONSHIPS WITH LOCAL COMMUNITIES OF RECOVERY

Role Clarity/Integrity: George, who is a salaried RC, has a practice of linking those he coaches to recovery communities by taking them to, and participating with them in, particular recovery support meetings. A complaint has come to the agency about George's "getting paid" for the time he is in meetings, with the charge that this constitutes accepting money for Twelve-Step work. What are the ethical issues here? How might George more clearly delineate his paid activity from his NA service work?

The values of stewardship require that the RC carefully allocate his or her time. George should be careful to separate RC hours from hours spent in recovery support meetings so as not to receive payment for meeting time. The RC function stops at the doorway of recovery support meetings: George should introduce his client to other recovery support group members and "hand him off" for Twelve Stepping.

Discretion (Example 1): You are working as a recovery coach attached to a treatment agency. You take an assigned client, Troy, to a local recovery support meeting, and you stay for the meeting. At the meeting, Troy discloses information that he has not told his counselor at the treatment program. Is this information you have heard considered confidential, or do you have an obligation to report it to the counselor?

The information disclosed at the meeting may not be revealed outside the meeting. To do so would violate recovery mutual-aid values and place the RC in the role of "undercover agent" at such meetings. You can encourage Troy to take the information to his counselor. This is another example of the strong need for ongoing supervision and support to help the RC deal with complex issues regarding his or her role.

Discretion (Example 2): Claude has been in and out of treatment and NA multiple times and has an off-and-on-again relationship with you as a recovery coach. Today you run into Rudy, one of Claude's former NA sponsors with whom you collaborated, in the mall. Rudy's first comment to you is, "How's our boy doing?" How do you respond? Would this be an appropriate disclosure or simply gossip? Do the confidentiality guidelines that cover treatment relationships (and which would prohibit any disclosure in answer to Rudy's question) extend to the recovery coach relationship?

If you are in an organization covered by federal confidentiality regulations (e.g., a treatment agency), you may not respond to that question, or even acknowledge that Claude is a client at your organization, unless you have a release signed by Claude specifying that you may speak to Rudy about him. If you are in an organization not covered by federal confidentiality regulations (e.g., a free-standing recovery support organization, a recovery ministry within a church), your response should be guided both by your organization's policies on confidentiality and discretion and by the agreement about permitted disclosures of communications that you negotiated with Claude at the beginning of the RC relationship. The key thing here is the value of fidelity: to keep our promises.

Anonymity: Ernest is a long-time AA member, recovery advocate, and recently hired recovery coach. In his earlier recovery advocacy work, Ernest has always been very careful in identifying himself publicly as a "person in long-term recovery," without noting his AA affiliation. Today, Ernest is on a panel at a local social service conference to talk about the pilot recovery coaching project in which he works. The conference is being covered by local media, who ask to interview Ernest after the panel. One of the reporters follows up Ernest's report of his recovery status and its duration with the question, "Are you a member of AA?" What are the ethical issues involved in this situation? How should Ernest respond? How would this be different if Ernest was in an alternative recovery support group that did not have a tradition of anonymity?

Ernest should NOT disclose his membership in AA. This would violate AA's anonymity tradition and might be viewed as a personal endorsement of a particular mutual-aid group. Such a disclosure and the potential controversy spawned by it could interfere with Ernest's service relationships, isolate Ernest from the local AA community, and harm the relationship between Ernest's organization and the local AA community. If Ernest were not in AA or another Twelve Step program, there would be no explicit anonymity guideline, but Ernest would still need to be cautious in any disclosures at the level of press.

Predatory Behavior: Felicia works as a recovery coach for women who are just entering intensive outpatient treatment and living in a women's recovery home. One of Felicia's responsibilities includes linking these women to local recovery mutual-aid meetings. Many of the women Felicia works with have histories of sexual victimization as well as long histories of toxic intimate relationships. Felicia is aware that predatory behavior ("Thirteenth Stepping") is common in some local recovery meetings. To what extent is Felicia responsible for preparing the women she refers for such behavior or protecting them by linking them to meetings with a strong group conscience?

Felicia needs to honor the potential of her clients to be harmed in groups with little "group conscience." She should assist her clients in finding meetings with a "climate" that is safe and supportive.

Potential Iatrogenic Effects of Recovery Coaching: Ellen, a highly respected elder in the local AA community, is expressing criticism of recovery coaches and the broader recovery support services offered by a local recovery advocacy agency. It is Ellen's position that such roles and services will undermine the importance of sponsorship and weaken the service ethic within the local recovery community. How do you respond?

Ellen should be invited to discuss her views on recovery coaching and shown the statistics and local experience related to the role of recovery coaching in successful long-term recovery. You should also solicit ideas from Ellen about how the recovery coach's role might be designed and supervised to ensure that it enhances rather than undermines the service ethic within the local AA community.

Role Integrity: Mel is an elder statesman in AA who offers to volunteer as a recovery coach. Mel's orientation to coaching is to do what he does as a sponsor: help people work the steps and develop a life of sobriety and serenity. What harm, if any, could come from this merger of the sponsor and recovery coach roles?

The primary harm in this merger of RC and sponsor roles would come from the broader recovery-support needs (e.g., sober housing, medical needs, transportation, day care) that would be addressed in the fully developed RC role but not addressed in the RC-as-sponsor role. Harm to the client could also result from the confusion between the RC and sponsor roles.

SUMMARY

This essay has described a model of ethical decision making for recovery coaches and their supervisors and identified some of the emerging ethical issues in the delivery of peer-based

recovery support services. Ethical sensitivities and approaches to ethical decision making will continue to evolve as recovery support services become more formalized and the collective experience of recovery coaches and their sponsoring organizations grows. This growing foundation of experience will spawn formal ethical guidelines for recovery coaches and more formal approaches to ethical decision-making. PRO-ACT has created a peer services ethics advisory panel and a set of ethical guidelines for its peer specialists that we expect will become more refined in the coming years. We have included a description of the advisory panel and these guidelines as appendices to this paper.

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Acknowledgments: Support for development of this paper was provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services. Grateful appreciation is extended to the Ethics Workgroup of the Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT) for its invaluable assistance at every stage in the development of this paper. Particular thanks are extended to the following individuals for their review and comments on early drafts: Ben Bass, Tom Hill, Jesus Magallanese, Cheryle Pacapelli, Joe Powell, and Phil Valentine.

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APPENDICES

A. Ethical Decision-making Worksheet
B. PRO-ACT Peer Specialist Code of Ethics
C. "The Law and Peer-Based Recovery Support Services," Prepared by Renée Popovits and Elizabeth Donohue

ETHICAL DECISION-MAKING WORKSHEET

Step One: Who is vulnerable to harm in this situation, and what is the potential degree of such harm?

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

Step Two: What core recovery values apply to this situation, and what action would they suggest be taken?

✓	**Core Recovery Value**	**Suggested Course of Action**
	Gratitude & Service	
	Recovery	
	Use of Self	
	Capability	
	Honesty	
	Authenticity of Voice	
	Credibility	
	Fidelity	
	Humility	
	Loyalty	
	Hope	
	Dignity and Respect	
	Tolerance	
	Autonomy & Choice	
	Discretion	
	Protection	
	Advocacy	
	Stewardship	

Step Three: What laws, standards or historical practices might guide your conduct in this situation?

Step Four: Where risk of injury is great to multiple parties, document:

- What you considered:

- Who you consulted:

- What you decided and did:

- The outcome of the decisions you made and actions you took:

Preamble

PRO-ACT acknowledges its duty and obligation to those individuals, families, and communities it serves to assure the delivery of peer support according to recovery-focused guidelines, principles and values. Toward that end, we have: **1)** defined a code of conduct within a value-driven decision-making process that will guide delivery of our services and our service relationships; **2)** developed a Peer Specialist Review Panel; **3**) established ethical guidelines for the delivery of peer-based recovery support services provided through PRO-ACT; and **4)** outlined the process for recruiting and screening of potential peer specialists, training requirements both initial and ongoing, ongoing support, and supervision.

Value Oriented Decision-making Process

All PRO-ACT staff and volunteers shall follow the recovery guidelines and principles when making decisions involving complex choices, choices in which one or more parties could be injured by what we do or fail to do. They will develop the ability to recognize an ethical dilemma using the PRO-ACT decision-making questions to clarify their choices.

1.) Recognize when a situation arises that is a value-related issue.

2.) Use the PRO-ACT value-driven decision-making questions to clarify your choices.

3.) Seek consultation from supervisor and consider guidance from the Peer Specialist Panel to make the best possible decision.

4.) Communicate what you did, your rationale for what you did, and the outcome of the decision to your supervisor for purposes of review and documentation.

5.) Debrief the experience with others at PRO-ACT to enhance the sensitivities and ethical decision-making abilities of others.

Principle Decision-making Questions

All PRO-ACT staff and volunteers shall answer three questions as part of their process of ethical decision-making:

1) Who has the potential of being harmed in this situation and how great is the risk for harm?

2) Are there any core recovery values that apply to this situation and what course of action would these values suggest be taken?

*In this document the titles Recovery Mentor, Peer Specialist, and Recovery Coach are interchangeable. For brevity, the Peer Specialist terminology will be utilized.

3) What laws, organizational policies, or ethical standards apply to this situation, and what actions would they suggest or dictate?

Peer Specialist Panel

The Peer Specialist Panel consists of three to five individuals who volunteer their talents and time to assist PRO-ACT in analyzing and responding to complex value-related questions or dilemmas. This committee/panel will be made up of individuals in long-term recovery (with more than four years continuous recovery) who are widely known in the recovery community for their personal integrity, who can analyze and respond to complex principle dilemmas, and offer guidance in a timely and consistent manner when complex value issues arise.

Each panel member serves a yearly term that may be extended by mutual agreement between each panel member and PRO-ACT. The Panel must meet on a routine basis to set up their operational guidelines and to also be available in a timely fashion to respond to Peer Specialist complex principle or guideline dilemmas.

The Peer Specialist Review Panel will have input into the continuing education and training requirements of peer specialists based in part on the principle and guideline dilemmas that are presented to assure a continuous learning process is available for all parties.

All proceedings of the Peer Specialist Panel shall be recorded by the chair of the panel, and records of these meetings shall be kept for at least five years in confidential locked files.

Process for Recruiting, Screening, Training, and Supervision needs of Peer Specialists

PRO-ACT will use non discriminatory practices to recruit members of the Recovery Community representing a broad spectrum of recovery pathways. PRO-ACT will screen all applicants in order to assure the safety of all involved. All Peer Specialists and their supervisors are required to attend initial and ongoing trainings to enhance their job performance. PRO-ACT will develop trainings to enhance the various skills required, and will also focus on creating trainings to enhance Peer Specialists' cultural sensitivity and other issues of importance to the Recovery Community. PRO-ACT will provide opportunities to share and discuss complex principle or guideline dilemmas.

PRO-ACT Principles and Guidelines for Peer Specialists

As a Peer Specialist, I understand that my sole mission is to help individuals and families recover from addiction and its related problems. To that end, I will help remove or overcome all obstacles to recovery and help each individual and family find resources within and beyond themselves to both initiate and sustain the recovery process. My actions will be guided by the following core recovery values and service guidelines.

Gratitude & Service

I understand that my service to others is a sacred trust and that my actions flow from myself, from PRO-ACT, and from the larger recovery community. I offer my experience, strength, and hope to assist others in recovery out of gratitude to those who assisted me in my recovery.

Personal Recovery

I will work on my recovery so that I may be beneficial to those who depend on me for recovery support.

Face and Voice of Recovery

I will be a good example of recovery for those I serve.

Self-Improvement

I will foster self-improvement.

Honesty

I will tell the truth and when wrong, I will promptly admit it.

Authenticity

I will carry the recovery message in word and in deed.

Keeping Promises

I promise to keep my promises.

Humility

I will work within my limitations, handle disagreements respectfully, and seek help when I need it.

Loyalty

I will serve others as others served me and promote the recovery mission of PRO-ACT.

Hope

I will help others focus on their assets, strengths, and recovery possibilities.

Respect

I will honor the imperfections of others and myself and treat those seeking recovery with dignity.

Acceptance

I accept all pathways to recovery however diverse, even those opposite my own.

Recovery Integrity

I can carry the message, but I cannot carry the person. I help others by empowering the recovery of others.

Protection

I do no harm by respecting privacy and refraining from gossip. I avoid all forms of exploitation or harassment of those I serve. Our relationship is a sanctuary of safety.

Advocacy

I confront injustice when necessary on behalf of those who have not been empowered but never do for others what they can do for themselves.

Stewardship

I use or create resources in the wisest way possible to provide benefits others need to achieve recovery.

THE LAW AND PEER-BASED RECOVERY SUPPORT SERVICES

Prepared by Renée Popovits and Elizabeth Donohue

Overview

While the peer-based recovery support services trend within the addiction treatment community is not new, these services have rapidly expanded in recent years under various names, such as recovery coaches, recovery mentors, and peer specialists. Furthermore, these roles do not fit neatly within the "traditional" addiction treatment field, and little guidance can be found concerning the complex ethical and legal issues that arise when providing peer recovery support services.

Since this is uncharted territory, we have created this Addendum with the goal of providing a brief analysis of some common legal issues that addiction treatment providers address daily, and how these issues may or may not affect those providing peer recovery support services. Specifically, this article addresses the following issues:

- The application of 42 C.F.R. Part 2
- The application of the Health Insurance Portability and Accountability Act (HIPAA)
- Mandatory Child Abuse Reporting
- Informed Consent
- Organizational Liability

Federal Confidentiality Considerations

Confidentiality protections exist to encourage people to seek treatment for addiction to alcohol or other drugs or a mental illness. Mental health confidentiality is generally governed by state law as well as the federal HIPAA Privacy Standards. On the other hand, addiction treatment programs meeting certain criteria are governed by very stringent federal regulations (42 C.F.R. Part 2), which, in most cases, are far more protective of patient confidentiality than the HIPAA Privacy Standards.

Several providers furnishing recovery support services have questioned whether 42 C.F.R. Part 2 ("Part 2") applies to such services. To assist in determining the applicability of Part 2 to recovery support services, this article includes a decision-making diagram, contained in Exhibit A. The key questions a recovery support provider needs to consider are:

- Is the service a federally assisted "program" or part of a program within the meaning of Part 2?

- Is the service rendered by an employee or a volunteer of a "program"?

- Has a "program" contracted with a Recovery Support Specialist to render services as part of its continuing care?

- Is the person to whom you are providing recovery support services a "patient" within the meaning of Part 2?

- What are the services furnished by the Recovery Support Specialist, and are these services covered by Part 2?

- Do you receive or have access to "patient identifying information" protected by Part 2?

These questions are explored more fully below.

Are You a Federally Assisted Program?

The first legal consideration is the obligation to comply with the confidentiality restrictions imposed under federal law and regulations (42 U.S.C 290dd and 42 C.F.R. Part 2, respectively). The federal regulations prohibit "federally assisted substance abuse treatment programs" from communicating patient identifying information unless the regulations expressly authorize such disclosures for the purpose of treating substance use disorders, making a diagnosis for that treatment, or making a referral. A "federally assisted substance abuse program" is defined as an addiction treatment program that is:

1. Conducted in whole or in part by any department or agency of the United States;

2. Carried out under a license, certification, or registration or other authorization including certification under the Medicare program; authorization to conduct methadone maintenance treatment; or registration to dispense a substance under the Controlled Substances Act, to the extent that the controlled substance is used in the treatment of addiction;

3. Supported by funds provided by any department or agency of the United States, including receipt of Federal financial assistance in any form, including assistance from the State or a local government unit which in turn receives Federal funds that could be used for addiction treatment; or

4. An IRS tax-exempt entity.

Federally assisted programs, as used in Part 2, include programs funded by the federal government, as well as programs conducted under a license, certification, registration, or other authorization granted by any federal department or agency, including Medicare certification or authorization to conduct methadone maintenance treatment. Federal assistance also includes tax exemption granted by the IRS. Even if the program does not meet the definition of a federally assisted program, state law or state licensure regulations may require adherence to Part 2. This is because states can impose the same or more stringent requirements than Part 2. For instance, in Illinois, recovery homes have to comply with Part 2 via the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse licensure regulations. If this State licensure mandate did not exist, recovery homes would not be subject to Part 2 because they do not provide treatment services within the meaning of Part 2.

Are You An Employee of a Federally Assisted Program?

If the program meets the definition of a "federally assisted substance abuse program," then individuals who are providing peer recovery support services through the covered program must also decide whether they would be considered employees of the program for the purposes of Part 2, and would therefore need to comply with these regulations. Generally, if a Recovery Support Specialist is employed directly by a program and is receiving reimbursement by the program for the services he or she provides, the Recovery Support Specialist would be considered an employee. This applies even though the Recovery Support Specialist is not providing direct addiction treatment services to clients. If the Recovery Support Specialist is an employee, and has access to protected information through work (in whatever capacity) with the program, then the Specialist must comply with Part 2 (see 42 C.F.R. 2.12).

Do You Have a Contractual Relationship With a Program?

However, if the Specialist is not directly employed or affiliated with the program, but provides services to the program as part of a "continuum of care," most often through a contractual arrangement, then the Specialist would be considered a "Qualified Service Organization" (QSO) of the program. A QSO provides contractual services to the program that include access to information protected by Part 2. A QSO Agreement would be executed between the program and the Specialist and would contain provisions requiring the Specialist to protect the information received in the course of the work the Specialist is doing with the program.

Are You a Volunteer of a Program?

If the Recovery Support Specialist is providing services on a strictly volunteer basis, and is receiving no reimbursement for the services provided, then the Recovery Support Specialist must determine whether he or she would have access to protected information, and if he or she is providing services to a covered program. If the answer to these questions is yes, then the Recovery Support Specialist must comply with Part 2.

Is the Person You Are Providing Support To a Patient?

Part 2 strictly governs the disclosure of any information, whether recorded or not, that would either directly or indirectly identify a client as a person with an alcohol or other drug problem. Protection is afforded to each "patient" in a program, meaning any individual who has applied for or been given diagnosis or treatment for alcohol- or other drug-related problems at a federally assisted program. This includes any individual who, after arrest on a criminal charge, is identified as having an alcohol- or drug-related problem in order to determine that individual's eligibility to participate in a program.

Under Part 2, the confidentiality protections extend to "patients" in a program. Once an individual becomes a patient, all individually identifiable information about that patient is protected. Applicants for addiction treatment services are patients even if they are not admitted to the program. However, a person who does not show up for an appointment for an assessment to determine whether a substance-related problem exists is not a patient. Former patients and deceased patients remain protected as well.

Are You Providing Services To the Patient?

In some cases, Recovery Support Specialists will be employed by, or work with, Recovery Community Organizations (RCOs) that provide non-clinical recovery support services through paid and volunteer staff and act as "drop-in centers," service hubs, and places of fellowship. Remember, Part 2 applies only to programs and to those individuals who are employed by, or affiliated with, those programs. If the RCO does not meet the definition of a covered program, then Part 2 will not apply, unless there are more stringent State licensing or funding regulations. In addition, however, the RCO and/or the Recovery Support Specialists will need to make a determination whether the support they provide meets the definition of a "covered service" under Part 2. Some questions to be asked include:

1. Does the RCO provide "diagnosis" for clients? A diagnosis is defined as "any reference to an individual's alcohol or drug abuse, or a condition which is identified as having been caused by that abuse, which is made for the purpose of treatment or referral for treatment." However, this is not limited to assessments by medical professionals. An evaluation or assessment carried out by a counselor would be considered a "diagnosis" covered by the regulations. However, a "screen" or "prescreen" to identify individuals who may need to be referred to a specialist for a diagnosis would not be covered by Part 2.

2. Are targeted prevention services provided that are aimed at individuals who have been identified as having substance-related problems? If so, these services are covered by Part 2.

3. Is the referral of an individual to addiction treatment made after an assessment or diagnosis has been made? A referral for services alone is not enough to be covered by Part 2, but if the referral is made after a "diagnosis" has identified the person as suffering from a substance use disorder, then Part 2 applies. A referral for housing, medical care, or other similar services would not trigger Part 2.

For an in-depth discussion of each type of service rendered by a Recovery Support Specialist, consult the Legal Action Center's analysis in its newsletter *Of Substance*, entitled "Recovery Support Services – Are They Covered by the Confidentiality Regulations? Part I" (Vol. 26, No.3 May/Jun 2005).

Do You Have Access To Protected Information?

The drug and alcohol confidentiality regulations restrict both the disclosure and the use of information about individuals in federally assisted addiction treatment programs. 42 C.F.R. 2.3(a). Records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any program or activity relating to alcohol dependence or alcohol abuse, or in connection with the performance of any drug abuse prevention function, which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States, must be kept confidential. 42 C.F.R. 2.12(a) and (b).

Patient identifying information is defined broadly to include any information whereby the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information. The Privacy Standards also protect information that identifies or could reasonably be used to identify an individual. The Privacy

Standards contain many of the same "identifiers" as Part 2, as well as numerous additional identifiers which are afforded protection (i.e., client ID numbers). See the glossary for definitions of Protected Health Information (PHI) under HIPAA and patient identifying information under Part 2. It is also worthy to note that Part 2 covers any information (written or oral) relating to a patient that is received or acquired by a federally assisted addiction treatment program. The Privacy Standards cover PHI about an individual (oral, written, etc.) only when maintained, collected, used, or disseminated by or for a covered entity.

Records are broadly defined to include "verbal" (spoken) communications as well as what is typically thought of as written medical records. Therefore, patient records include any information relating to the patient, written or oral. In addition to disclosing any of the patient identifying information above, there are other ways of disclosing patient information (for example, giving written records with a patient's name on it or answering a telephone and informing the caller that the person to whom the caller wishes to speak is present).

the Health Insurance Portability and Accountability Act of 1996 (Hipaa)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to provide better access to health insurance and to toughen the law concerning health care fraud. In addition, it created national standards to facilitate the electronic exchange of health information and protect the privacy of any patient-identifying health information.

An addiction treatment "program" required to comply with Part 2 is not automatically a covered entity under the Privacy Standards of HIPAA. A covered entity is a health plan, health care clearinghouse, or health care provider who transmits any health information in electronic forms in connection with a covered transaction.

The Privacy Standards establish a federal floor of safeguards to protect the confidentiality of medical information by limiting the disclosure of PHI. PHI is any individually identifiable health information in **any** form: electronic, written, oral, or any other form. Protected health information may not be used or disclosed except as authorized by the patient or as permitted by the regulations. In other words, if the provider does not transmit any health information electronically, the provider is not a covered entity under the Privacy Standards. If the provider transmits health information in connection with covered transactions (see glossary) electronically via the Internet; an extranet; private networks; e-mail; or transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk, etc. then the privacy standards apply, even if all other information is kept in paper form.

Therefore, assuming the treatment agency is both a "Program" under Part 2 and a "covered entity" under the HIPAA Privacy Standards, PHI becomes protected upon its creation or receipt by the provider of treatment for substance use disorders (SUDs)[3]. The person does not have to be admitted as a patient. If a person calls and makes an inquiry and the addiction treatment abuse agency documents identifying information about the individual, the information would be considered PHI. This protection applies to any PHI in any form and remains protected for as long as the covered entity transmits or maintains it.

However, we should note that, based on the functions and services provided by RCOs, we believe it very unlikely that HIPAA would apply to RCOs, since RCOs would not be engaging in

[3] In cases where the 42 C.F.R Part 2 and the Privacy Standards apply and conflict, the more stringent of the two laws will apply.

electronic healthcare transactions. Therefore, the RCO would not meet the definition of a "covered entity" under HIPAA. In addition, based on a review of the functions and duties of Recovery Support Specialists, we have concluded that Recovery Support Specialists are not engaging in electronic healthcare transactions that would make them covered entities under the HIPAA.

How Do You Share Protected Information?

There are a number of ways to share protected health information without breaching a client's confidentiality. The most obvious is to use de-identified information or to disclose the information without identifying the person as a recipient of SUD treatment services. If you need to include patient identifying information, you may legally disclose: (1) with written patient authorization; (2) with a valid court order; (3) to staff within the program; (4) to a qualified service organization; (5) under a child abuse reporting exception; (6) to law enforcement for a crime on program premises or against program personnel; (7) to health care personnel for medical emergencies; (8) for research; and (9) for audit/evaluation activities.

Patient identifying information includes the name, address, social security number, fingerprints, voiceprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information (42 C.F.R. Section 2.11). In order to release this information, the regulations require the execution by the patient of a valid consent. Consents for disclosure are governed by the federal confidentiality regulations (42 C.F.R. Section 2.31) and must be in writing. To make a disclosure in accordance with these regulations, the following elements must be included in the written consent:

(1) Name of patient
(2) Name or general designation of program making the disclosure
(3) Kind of information and amount of information to be disclosed
(4) Name or title of person or organization to which disclosure is to be made
(5) Purpose for disclosure
(6) Date on which consent is signed
(7) Signature of patient
(8) Signature of parent or guardian, if applicable
(9) Statement that the consent is subject to revocation (except to the extent program has relied upon it)
(10) Statement that the consent will terminate upon a specific date, event, or condition

The federal confidentiality statutes and regulations, as discussed above, govern consent for disclosure. Prior to making a disclosure, a written consent form (containing the required elements of 42 C.F.R. 2.31) should be signed by the patient.

Mandatory Child Abuse Reporting

All fifty states have provisions for mandatory reporting of physical and/or sexual abuse of children. These statutes are based on the premise that the potential harm to children from abusive acts outweighs the potential harm that could occur through the violation of client confidentiality. The ethical command is to ensure that abuse does not recommence and to ensure the safety of other potential victims. The key question will be whether Recovery Support Specialists fall within a state's definition of a mandated reporter. If that is the case, there are three approaches the Recovery Support Specialist may follow.

The first approach takes the position that the Specialist should report only those cases of abuse that clearly fall under the definition of legally mandated reporting. This option makes compliance with the law the framework for ethical conduct. The risk here is twofold: first, that cases may arise in which there is an ethical mandate to protect which falls outside the legal requirement to report; and second, that actions taken to protect—mandatory reporting—may, in some unique circumstances, do harm to those targeted for protection.

The second approach takes the position that the Specialist should report only in those circumstances in which there is a legal obligation to report AND the action of reporting is judged by the Specialist to be the best available vehicle capable of protecting the innocent parties and supporting the long-term health and safety of all parties involved. With this option, a judgment not to report is an implicit assumption of responsibility and legal liability by the Specialist for the welfare of those involved, but one deemed justifiable under certain circumstances. In fact, in some states, a mandated reporter's failure to report child abuse or neglect is typically a misdemeanor, and grounds for disciplinary action by applicable licensing boards, if the Recovery Support Specialist possesses any such licenses. To further encourage reporting, some states also have immunity provisions for those who report abuse and neglect.

The third approach posits that the specialist should report, not only those cases that fall under the definition of legally mandated reporting, but also cases where the Specialist feels an ethical duty to protect but circumstances are not of such severity as to legally require reporting. The risk in this option is of unduly violating client confidentiality and of adding non-critical work to an already overburdened child protection system. Once again, if the specialist reports in "good faith," some state statutes provide immunity for such reporting.

For example, the Pennsylvania Consolidated Statutes, Title 23 (Domestic Relations), Chapter 63, states that any people who come into contact with children in the course of their employment, occupation, or practice of their profession shall report a reasonable suspicion of child abuse. Mandatory reporters include "social services workers," "child care workers," and "mental health professionals." In addition, child care services are defined to include "early intervention and drug and alcohol services for children."

Therefore, if the Recovery Support Specialist is also a mental health professional, the Recovery Support Specialist is a mandated reporter and must report child abuse under the statute. However, if (for example) a Recovery Support Specialist in Pennsylvania were not also engaged in a profession which is defined as that of a mandated reporter, there would not be a legal duty to report child abuse under the statute, but there might be an ethical duty to report governed by professional codes of conduct.

When in doubt, a Recovery Support Specialist should report child abuse. As stated above, most states have immunity provisions for those who report child abuse in good faith. In addition, the Recovery Support Specialist could face greater liability for not reporting. Furthermore, if the Recovery Support Specialist is not covered by Part 2, he or she will not be restricted by those regulations concerning the types of information he or she may disclose in connection with a suspicion of child abuse.

To reconcile the client's right to confidentiality with the duty to report, it is crucial that each agency clearly defines how it operationalizes both of these mandates within the span of the three positions noted above. Once that position has been determined, clients can be told of the

exceptions to confidentiality in language precise enough to allow them to make informed choices regarding likely responses to their disclosures.

There are numerous variations on abuse situations that make it more difficult to sort out one's legal and ethical duties. The agency/specialist response to each situation can be discussed using the following questions:

- Does the situation, as presented, warrant suspension of confidentiality and reporting to an outside authority? If yes, which outside authority?

- What actions in addition to, or as an alternative to, external reporting would enhance the protection of safety in the situation?

- Who will benefit, and who may be harmed by the proposed action?

- Which ethical values should guide our response to the situation?

Personal Or Organizational Liability

In general, courts have required that the patient be told: (1) the nature and purpose of the procedure; (2) the risks and consequences; (3) the alternatives; and (4) the risks of no treatment. Failure to disclose risk is the most common source of liability. This concept is known as informed consent. Because of the nature of Recovery Support Services, this concept of informed consent does not appear to apply. Nevertheless, people providing such services have questioned under what circumstances personal or organizational liability might accrue.

To determine whether a professional practice standard was breached, courts would look to the standards of what a reasonably prudent Recovery Support Specialist in the community would do in exercising reasonable care, as well as any statutory or regulatory requirements to determine the "appropriate standard of care." Liability in these cases is typically imposed on the individual as well as the agency under negligence theories. Thus, the plaintiff would be required to prove that the peer specialist had a duty and breached the duty, and that the client suffered injury as a result of the breach (meaning the peer specialist caused the client's injury) and damages were sustained. The key question in these cases is often whether the patient can prove that, had the risk been disclosed, he or she would not have consented to the procedure or treatment. In addition, liability could be imposed on the agency for failure to meet certain standards of care with respect to negligent hiring, training, supervision, or retention of staff. Some of the licensure, business, legal, and employment considerations that could impact these decisions and standards of care are:

- Will licensure regulations be modified to address this new role and the minimum standards for the state's seal of approval?

- Will funding agencies impose requirements on agencies employing this new role?

- Will these peer support roles be perceived as members of the "treatment team"? Are they volunteers? Are they interventionists? Are they case managers/outreach workers? Where do these roles fit in the continuum of care and supervision of the clinical team?

- Will reimbursement mechanisms for these new services drive the standards of care and associated breaches of those duties?

- Will certification agencies establish the standards of care and associated breaches of those duties?

- Will credentialing and other regulatory bodies establish the minimum credentials of those qualified to render services, thus imposing the corollary obligation to engage in appropriate recruitment, orientation, training, and supervision of the peer support specialists?

- What responsibilities will be imposed on Recovery Support Specialists to document their services?

- Will the existence of documentation change the role, expectations, and assumed liability of these peer support specialists?

- Will agency approaches to minimum sobriety "guidelines" impact the success of recruiting qualified peer support recovery specialists?

- Will agency codes of ethics relating to peer relationships with fellow clients affect "bright line prohibitions" of professional behaviors in the employment context?

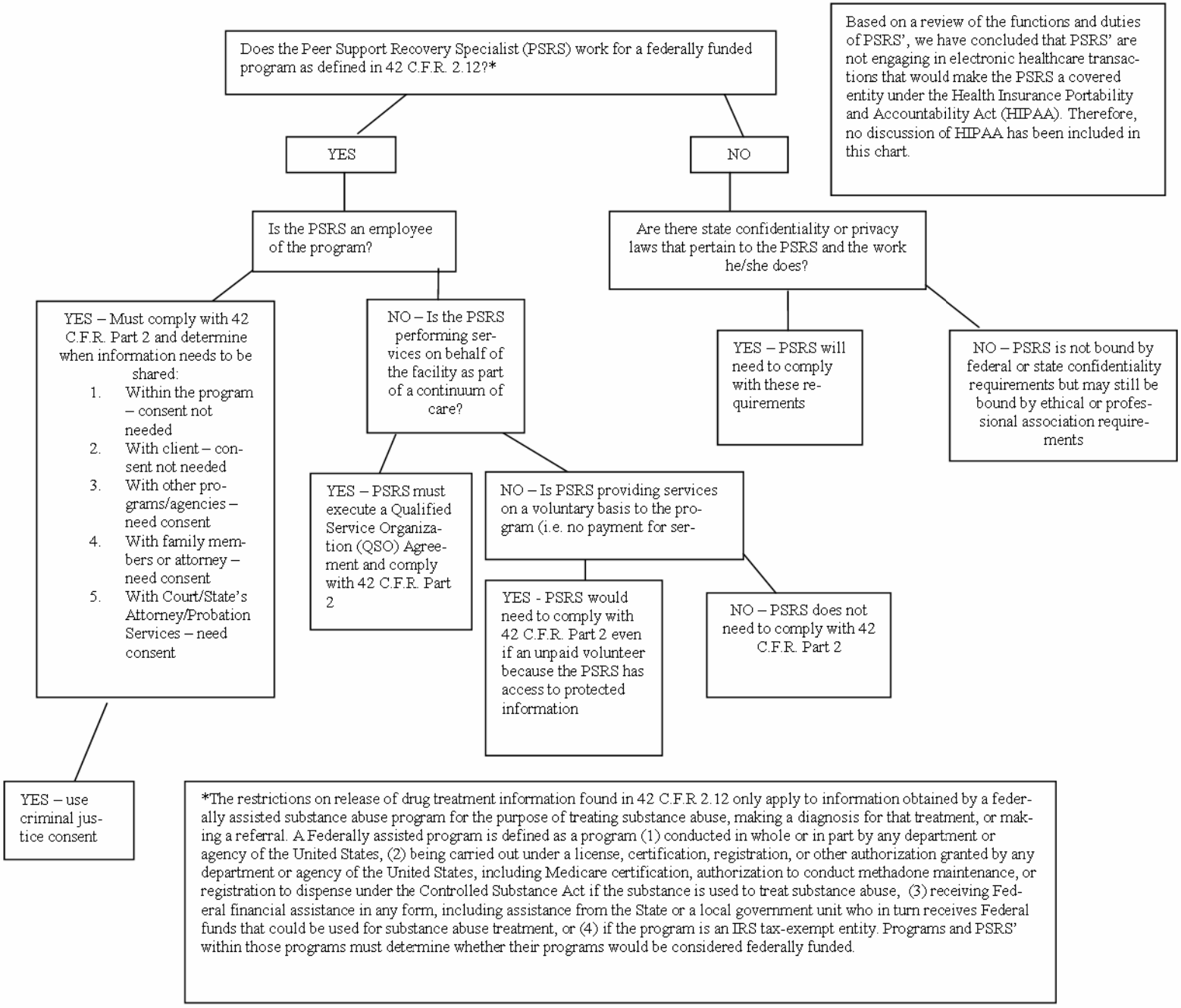
- What similarities exist between Recovery Support Specialists and consumer employees in the mental health field? What challenges have been encountered and lessons learned from that field that can be replicated for these positions?

- Will restrictions need to be imposed to "wall off" Recovery Support Specialists from information in a client record (including but not limited to joint clinical staffing to discuss client issues, the written medical record, the electronic information in clinical and billing systems), to preserve clients' right to confidentiality from fellow employee/fellow clients?

- With the Recovery Support Specialists presumably being involved with the clients for longer terms to support lifelong recovery, how does that impact the definitions of "clients" for purposes of determining whether a relationship can occur between a peer support recovery specialist and a "former client"?

At the present time, Recovery Support Services are deemed neither clinical nor medical procedures for which informed consent is required, and therefore there is a minor risk of liability. However, even as we speak, several states are modifying their licensure regulations to address Recovery Support Specialist services. Funding agencies will not be far behind. This public policy shift will have a huge impact on the nature of the services Recovery Support Specialists provide. As Recovery Support Specialists become an integral part of the treatment team and/or the continuum of care, we will witness licensing and funding authorities creating standards to govern these services, to justify reimbursement for them, and to create minimum levels of expectations. Once these standards are imposed, patients will have a greater ability to prove a breach of these standards and successfully sue Recovery Support Specialists for various types of liability.

Although standards professionalize the service, establish minimum public safety thresholds, and hold recipients of government funding accountable, mandated standards have contributed to survival strategies driving the addiction treatment field to focus on documentation, certifications, credentials, and reimbursement rather than the peer-based recovery concepts necessary for sustaining life-long recovery. This reality resulted in the peer-based recovery movement. Once federal, state, and local governmental authorities impose standards on these innovative recovery support services, they may very well destroy the effectiveness of the interventions that they choose to govern.


Does the Peer Support Recovery Specialist (PSRS) work for a federally funded program as defined in 42 C.F.R. 2.12?*
YES
NO
Based on a review of the functions and duties of PSRS', we have concluded that PSRS' are not engaging in electronic healthcare transactions that would make the PSRS a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). Therefore, no discussion of HIPAA has been included in this chart.
Is the PSRS an employee of the program?
Are there state confidentiality or privacy laws that pertain to the PSRS and the work he/she does?
YES – Must comply with 42 C.F.R. Part 2 and determine when information needs to be shared:
1. Within the program – consent not needed
2. With client – consent not needed
3. With other programs/agencies – need consent
4. With family members or attorney – need consent
5. With Court/State's Attorney/Probation Services – need consent
NO – Is the PSRS performing services on behalf of the facility as part of a continuum of care?
YES – PSRS will need to comply with these requirements
NO – PSRS is not bound by federal or state confidentiality requirements but may still be bound by ethical or professional association requirements
YES – PSRS must execute a Qualified Service Organization (QSO) Agreement and comply with 42 C.F.R. Part 2
NO – Is PSRS providing services on a voluntary basis to the program (i.e. no payment for ser-
YES - PSRS would need to comply with 42 C.F.R. Part 2 even if an unpaid volunteer because the PSRS has access to protected information
NO – PSRS does not need to comply with 42 C.F.R. Part 2
YES – use criminal justice consent
*The restrictions on release of drug treatment information found in 42 C.F.R 2.12 only apply to information obtained by a federally assisted substance abuse program for the purpose of treating substance abuse, making a diagnosis for that treatment, or making a referral. A Federally assisted program is defined as a program (1) conducted in whole or in part by any department or agency of the United States, (2) being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States, including Medicare certification, authorization to conduct methadone maintenance, or registration to dispense under the Controlled Substance Act if the substance is used to treat substance abuse, (3) receiving Federal financial assistance in any form, including assistance from the State or a local government unit who in turn receives Federal funds that could be used for substance abuse treatment, or (4) if the program is an IRS tax-exempt entity. Programs and PSRS' within those programs must determine whether their programs would be considered federally funded.

This article will be part of *Perspectives on Peer-based Recovery Support Services*, the third in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

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The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives

White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

Ethical Guidelines for the Delivery of Peer-based Recovery Support Services

William L. White, MA

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With a discussion of legal issues by Renée Popovits and Elizabeth Donohue

Prepared for the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS)

and

Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT)

INTRODUCTION

There is a long history of peer-based recovery support services within the alcohol and other drug problems arena, and the opening of the twenty-first century is witnessing a rebirth of such services (White, 2004a). These services are embedded in new social institutions such as

recovery advocacy organizations and recovery support centers and in new paid and volunteer service roles. These peer-based recovery support roles go by various titles: recovery coaches, recovery mentors, personal recovery assistants, recovery support specialists, and peer specialists. Complex ethical and legal issues are arising within the performance of these roles, issues for which little guidance can be found within the existing literature.

The twin purposes of this article are 1) to draw upon the collective experience of organizations that are providing peer-based recovery support services to identify ethical issues arising within this service arena, and 2) to offer guidance on how these issues can best be handled. Toward that end, we will:

- define the core responsibility of the peer recovery support specialist (here referred to generically as *recovery coach*);
- provide an opening discussion of key ethical concepts;
- outline a model of ethical decision making that can be used by recovery coaches and those who supervise them;
- discuss vignettes of ethical situations that can arise for recovery coaches related to personal conduct, conduct in service relationships, conduct in relationships with local service professionals and agencies, and conduct in service relationships with the larger community; and
- provide a sample statement of ethical principles and guidelines for recovery coaches.

An appended paper also identifies the extent to which current laws governing roles in addiction treatment (e.g., confidentiality, duty to warn, personal/organizational liability) are applicable to recovery coaches and their organizations.

We have two intended audiences for these discussions: individuals who are in positions of responsibility for the planning, implementation, and supervision of peer-based recovery support services and individuals who are working in either paid or volunteer roles as recovery coaches. This paper is designed to be adapted for use in the training of recovery coaches and their supervisors. The paper will remain in the public domain and may be adapted as a training aid or used without request by other recovery support organizations as a reading resource. We encourage the use of the decision-making model and the ethical case studies in the paper in the orientation and training of recovery coaches.

PEER-BASED RECOVERY SUPPORT ROLES AND FUNCTIONS[1]

Recovery support services, as the term is used here, refers to non-clinical services that are designed to help initiate and sustain individual/family recovery from severe alcohol and other drug problems and to enhance the quality of individual/family recovery. The Center for Substance Abuse Treatment's Recovery Community Support Program identified four types of recovery support services:

[1] This section excerpts material from White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor, 5*(6), 20-22.

- ***Emotional support****—demonstrations of empathy, love, caring, and concern in such activities as peer mentoring and recovery coaching, as well as in recovery support groups*
- ***Informational support****—provision of health and wellness information; educational assistance; and help in acquiring new skills, ranging from life skills to skills in employment readiness and citizenship restoration*
- ***Instrumental support****—concrete assistance in task accomplishment, especially with stressful or unpleasant tasks such as filling out applications and obtaining entitlements, providing child care, or providing transportation to support-group meetings and clothing assistance outlets (clothing closets).*
- ***Companionship****—helping people in early recovery feel connected and enjoy being with others, especially in recreational activities in alcohol- and drug-free environments*. This assistance is particularly crucial in early recovery, when little about abstaining from alcohol or drugs is reinforcing.

  (Source: http://rcsp.samhsa.gov/about/framework.htm)

Some of the service activities now provided within the rubric of recovery support services include activities performed in earlier decades by people working as outreach workers, case managers, counselor assistants, and volunteers. Recovery support services may be provided by clinically trained professionals as an adjunct to their clinical (assessment and counseling) activities, or they may be delivered by people in recovery who are not clinically trained but who are trained and supervised to provide such support services. They are being provided as adjuncts to other service roles or within specialty roles. Recovery support services are being provided by people working in full- and part-time paid roles and by people who provide these services as volunteers.

Peer-based recovery support roles are growing rapidly in the mental health and addiction service arenas. While there are specific issues related to peer-based services that are distinct within these two fields, the fields have much they can learn from each other.[2]

Part of what makes the ethical delivery of recovery support services so challenging in the addictions context is that the recovery coach performs so many roles. In service organizations piloting this role, the recovery coach is being described as a(n):

- Outreach worker (identifies and engages hard-to-reach individuals, offers living proof of transformative power of recovery, makes recovery attractive)
- Motivator and cheerleader (exhibits faith in capacity for change, encourages and celebrates recovery achievements, mobilizes internal and external recovery resources, encourages self-advocacy and economic self-sufficiency)
- Ally and confidant (genuinely cares and listens, can be trusted with confidences)
- Truth-teller (provides feedback on recovery progress)

[2] Particularly recommended are the following three resources from the mental health field: 1) Mowbray, C.T., Moxley, D.P., Jasper, C.A., & Howell, L.A. (Eds.) (1997). *Consumers as providers in psychiatric rehabilitation.* Columbia, MD: International Association of Rehabilitation Services; 2) Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2005). *Recovery from severe mental illness: Research evidence and implications for practice.* Boston: Center for Psychiatric Rehabilitation; and 3) Spaniol. L., Gagne, C., & Koehler, M. (Eds.) (1997). *Psychological and social aspects of psychiatric rehabilitation.* Boston: Center for Psychiatric Rehabilitation.

- Role model and mentor (offers his/her life as living proof of the transformative power of recovery, provides stage-appropriate recovery education)
- Planner (facilitates the transition from a professionally directed treatment plan to a consumer-developed and consumer-directed personal recovery plan)
- Problem solver (helps resolve personal and environmental obstacles to recovery)
- Resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support; matches individuals to particular support groups/meetings)
- Monitor (processes each client's response to professional services and mutual-aid exposure, to enhance service/support engagement, reduce attrition, resolve problems in the service/support relationship, and facilitate development of a long-term, sobriety-based support network; provides periodic face-to-face, telephonic, or email-based monitoring of recovery stability and, when needed, provides early re-intervention and recovery re-initiation services)
- Tour guide (introduces newcomers into the local culture of recovery; provides an orientation to recovery roles, rules, rituals, language, and etiquette; opens opportunities for broader community participation)
- Advocate (helps individuals and families navigate complex service systems)
- Educator (provides each client with normative information about the stages of recovery; informs professional helpers, the community, and potential service consumers about the prevalence, pathways, and styles of long-term recovery)
- Community organizer (helps develop and expand available recovery support resources, enhances cooperative relationships between professional service organizations and indigenous recovery support groups, cultivates opportunities for people in recovery to participate in volunteerism and other acts of service to the community)
- Lifestyle consultant/guide (assists individuals/families in developing sobriety-based rituals of daily living, encourages activities (across religious, spiritual, and secular) frameworks that enhance life meaning and purpose)
- Friend (provides sober companionship, a social bridge from the culture of addiction to the culture of recovery) (White, 2004a)

The fact that these functions overlap with other helping roles, including that of the addictions counselor, raises the potential for role ambiguity and conflict. Agencies experimenting with these new roles insist that the recovery coach is NOT a:

- sponsor,
- therapist/counselor,
- nurse/physician, or
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church) (See White, 2006a,c).

Role Boundary Integrity: The RC is NOT a:	**You are moving beyond the boundaries of the recovery coach role if you:**
Sponsor (or equivalent)	• Perform AA/NA or other mutual-aid group service work in your RC role • Guide someone through the steps or principles of a particular recovery program
Therapist/counselor	• Diagnose • Provide counseling or refer to your support activities as "counseling" or "therapy" • Focus on problems/"issues"/trauma as opposed to recovery solutions
Nurse/Physician	• Suggest or express disagreement with medical diagnoses (including psychiatric diagnoses) • Offer medical advice • Make statements about prescribed drugs beyond the boundaries of your training and experience
Priest/Clergy	• Promote a particular religion/church • Interpret religious doctrine • Offer absolution or forgiveness (other than forgiveness for harm done specifically to you) • Provide pastoral counseling

People serving as recovery coaches, rather than being legitimized through traditionally acquired education credentials, draw their legitimacy from *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge is information acquired about addiction recovery through the process of one's own recovery or being with others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others achieve and sustain recovery. Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise are ideal candidates for the role of recovery coach. The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery to those who have offered sustained living proof of their expertise as recovery guides (White & Sanders, 2006). The recovery coach works within a long tradition of wounded healers—individuals who have suffered and survived an illness or experience who use their own vulnerability and the lessons drawn from that process to minister to others seeking to heal from the same condition (White, 2000a,b; Jackson, 2001).

Recovery coaching at its best offers dimensions of recovery support not available from other service roles. We asked individuals from three states (Pennsylvania, Connecticut, and Texas) who had experienced recovery coaches what these recovery coaches contributed to their early recovery experiences. Here are some of their responses.

> *My recovery coach builds me up and makes me feel like I am someone and I can accomplish anything I set my mind to. He provides his experience in recovery and his strength and hope.*

> *Support. It's comfortable to have someone behind me—I don't think I could do it on my own. They always help me to look at things differently*.

My recovery coach is 100% real. She has been there and done that. She understands me and knows where I'm at in this point in my life. She knows exactly what to say and do for me to build me up and keep me strong. It's like we are on the same level and she is here to help me move on and get to the next step in my recovery and in my life.

*He gave me a little self-esteem. He asked me, was I ready? I was able to share my past. He helped place me in the Mentor Plus program. He walked me through. He told me it would not be eas*y.

Recovery coaching has helped me set goals in my life. It has also taught me to be accountable for my actions. The coach didn't really give advice, more like guidance to make better decisions on my own.

She helped me paint a picture that I am not alone, and that there are a lot of recovering addicts out there and they actually have a lot of clean time. I didn't know that before.

I wanted to become a responsible daughter and mother and a respected and productive member of the community. I started doing anything and everything for my recovery. One of the most important things was that I got mentors for the Mentor Plus program. They came to see me every week, eventually twice a week. They gave me direction and were there to support me.

His demeanor of recovery showed me I could get what he has.

Recovery coaches, particularly those serving in this capacity as volunteers, are also quite explicit in what they get out of this service process.

I like working with people and being able to offer encouragement and support. It's very rewarding to see people start getting their lives back. Sometimes I see people who don't make the right choices, and that can be frustrating, because I remember what that was like and I feel for them. It helps me to remain grateful for how much better my life is now that I'm in recovery, and I try to pass that message on to them. I am a part of a wonderful process, and helping others helps me more than I can say.

In helping individuals build and rebuild recovery capital, I have learned, not only a lot about these people, but a lot about myself.

Today I know that I don't know. In letting someone in on that secret, it reassures them that it is okay not to be all knowing and all powerful.

In being a recovery coach, I am able to make a small dent in the world around me and a huge change in my own life.

Personally, I love what I do. I have been helping people in recovery since the beginning of my recovery in 1989. I have been blessed to have such a great appreciation for helping others that it has become a part of me. There is no greater feeling than to help someone out of the gutter where I came from and see them grow.

I feel I am giving back by helping assist others in their recovery process. By practicing what I preach, I am able to build and nurture areas of spiritual growth in my life. I am

able to maintain a sense of integrity and character. Working as a recovery coach has helped me evaluate strengths and weaknesses and improve my listening skills. I feel trusted and valued as a mentor when people allow me to help them reach their goals. I feel special.

When that 'light' comes on, it is so exciting to witness. I do recovery coaching for selfish reasons…I'm looking for more 'light.'

Recovery coaching is in its frontier stage. The role is being defined differently around the country based on the unique needs of particular communities and particular client populations. That variability is both a source of strength (responsiveness to the particular needs of individuals, families, and communities) and a source of vulnerability (the lack of consistent role definition and prerequisites). Orientation, training, and supervision protocols for recovery coaches are in an early stage of development.

The excitement about the recovery coach's role is tempered by concerns about potential conflicts with other service roles, and concerns about harm that might come to recipients of recovery support services due to incompetence or personal impairment on the part of the recovery coach—concerns that apply to all health and human service roles. There are several characteristics of recovery support services that influence the vulnerability of consumers and providers of peer-based recovery support services.

First, recovery support needs span the periods of pre-recovery engagement, recovery initiation, recovery stabilization, and recovery maintenance. As such, these service relationships last far longer than the counseling relationships that are the core of addiction treatment, are far more likely to be delivered in the client's natural environment, and often involve a larger cluster of family and community relationships.

Second, recovery support relationships are less hierarchical (less differential in terms of power and vulnerability) than the counselor-client relationship, involve different core functions, and are governed by different accountabilities. Given these factors, the ethical guidelines that govern the addiction counselor are often not applicable to the recovery coach. Efforts to impose ethical standards from traditional helping professions might inadvertently lead to the over-professionalization and commercialization of the role of recovery coach and recreate the very conditions that created the need for peer-based recovery support services. Ethical guidelines for recovery coaches must flow directly from the needs of those seeking recovery and from the values of local communities of recovery.

Third, individual consumers of peer-based recovery support services differ in the kind of non-clinical support services they need, and it is not uncommon for the same person to need different types of support services at different stages of his or her addiction and recovery careers. This requires considerable care in evaluating support service needs, delivering those services within the boundaries of one's knowledge and experience, and knowing how and when to involve people in other service roles.

Fourth, peer-based recovery support services can constitute an adjunct to addiction treatment (for those with high problem severity and low recovery capital) or an alternative to addiction treatment (for those with low or moderate problem severity and moderate or high recovery capital). This requires considerable vigilance in determining service needs and providing services only within the boundaries of one's competence, and skill in making necessary referrals in a timely manner.

All of these conditions underscore the need for a clear set of ethical values and standards to guide the delivery of peer-based recovery support services.

ETHICS: A BRIEF PRIMER

The topic of ethics may be a relatively new one for recovery coaches who have never worked within or received services from an addiction-related service agency. Before proceeding to a discussion of how best to make decisions in the face of ethical dilemmas, we must further enhance our understanding of what we mean when we say that an action of a recovery coach is ethical or unethical. At its most primitive level, aspiring to be ethical involves sustained vigilance in preventing harm and injury to those to whom we have pledged our loyalty. This meaning is revealed through four terms: *Iatrogenic, Fiduciary, Boundary Management,* and *Multi-party Vulnerability*.

Iatrogenic means unintended, treatment-caused harm or injury. It means that an action taken to help someone, possibly with the best of intentions, actually resulted in injury or death. Can you think of an example of such an action? There is a long history of such insults in the history of addiction treatment, e.g., mandatory sterilizations, withdrawal using chemo- and electroconvulsive shock therapies, psychosurgery (e.g., lobotomies), and all manner of drug insults (e.g., treating morphine addiction with cocaine). It is easy today to look back on such "treatments" and wonder "What were they thinking?!" And yet history tells us that it is hard to see such potential injuries close-up. Given the new frontier of recovery coaching, we must be vigilant to quickly weed out well intended actions that harm one or more parties. This potential for harm also underscores the importance of seeking guidance from other recovery coaches and from supervisors.

Fiduciary—a word whose roots are linked to those of the word "faith"—describes relationships in which one person has assumed a special duty and obligation for the care of another. This word is a reminder that the relationship between the recovery coach and those to whom he or she provides services is not a relationship of equal power: It is not solely a supportive friendship. "Fiduciary" implies that one person in this relationship enters with increased vulnerability requiring the objectivity, support, and protection of the other—like a relationship we would have with our own physician or attorney. While the power differential between the recovery coach and those whom he or she coaches is less than that between a surgeon and his or her patient, the recovery coach can still do injury through what he or she does or fails to do. And so these relationships are held to a higher level of obligation and duty than would be friendships that are reciprocal in nature.

Boundary Management encompasses the decisions that increase or decrease intimacy within a relationship. This is an area of potentially considerable conflict between recovery support specialists and traditional service professionals. Where traditional helping professions (physicians, nurses, psychologists, social workers, addiction counselors) emphasize hierarchical boundaries and maintaining detachment and distance in the service relationship, peer-based services rely on reciprocity and minimizing social distance between the helper and those being helped (Mowbray, 1997). While addiction professionals and peer-based recovery support specialists both affirm boundaries of inappropriateness, they may differ considerably in where such boundaries should be drawn.

We might view the relationship between recovery coaches and those they serve upon an intimacy continuum, with a zone of safety in which actions are always okay, a zone of vulnerability in which actions are sometimes okay and sometimes not okay, and a zone of abuse in which actions are never okay. The zone of abuse involves behaviors that mark too little or too great a degree of involvement with those we serve. Examples of behaviors across these zones are listed in the chart below. Place a checkmark for each behavior based on whether you think this action as a recovery coach would be always okay, sometimes okay but sometimes not okay, or never okay.

Table 1: Recovery Coaching: An Intimacy Continuum

Behavior of Recovery Coach in Recovery Support Relationship	Zone of Safety (Always Okay)	Zone of Vulnerability (Sometimes okay; Sometimes not okay)	Zone of Abuse (Never Okay)
Giving a gift			
Accepting a gift			
Lending money			
Borrowing or accepting money			
Giving a hug			
"You're a very special person"			
"You're a very special person to me."			
Invitation to a holiday dinner			
Sexual relationship			
Sexual relationship with a mentee's family member			
Giving your cell phone number			
Using profanity			
Using drug culture slang			
"I'm going through a rough divorce myself right now."			
"You're very attractive."			
Addressing the person by his/her first name			
Attending a recovery support meeting together			
Hiring the person to do work at your home.			

Ethical issues that can arise in situations like those listed above will be explored later in this paper.

Multi-party Vulnerability is a phrase that conveys how multiple parties can be injured by what a recovery coach does or fails to do. These parties include the person receiving recovery support services, that person's family and intimate social network, the recovery coach, the organization for which the recovery coach is working, the recovery support services field, the larger community of recovering people, and the community at large.

It is easy for organizations providing recovery support services to make assumptions about ethical behavior and misbehavior that turn out to be disastrously wrong. Let's consider five such assumptions to open our discussion.

Assumption 1: *People who have a long and, by all appearances, high-quality sobriety can be counted on to act ethically as recovery coaches*.
Fact: Recovery, no matter how long and how strong, is not perfection. We are all vulnerable to isolated errors in judgment, particularly when we find ourselves isolated in situations unlike any we have faced before.

Assumption 2: *People hired as recovery coaches will have common sense.*
Fact: "Common sense" means that people share a body of historically shared experience that would allow a reasonable prediction of what they would do in a particular situation. The diversity of cultural backgrounds and life experiences of people working as recovery coaches provides no such common foundation, and behavior that is common sense in one cultural context might constitute an ethical breach in another.

Assumption 3: *Breaches in ethical conduct are made by bad people. If we hire good people, we should be okay.*
Fact: Most breaches in ethical conduct within the health and human service arena are made by good people who often didn't even know they were in territory that required ethical decision making. Protecting recipients of recovery support services requires far more than excluding and extruding "bad people." It requires heightening the ethical sensitivities and ethical decision-making abilities of good people.

Assumption 4: *Adhering to existing laws and regulations will ensure a high level of ethical conduct.*
Fact: The problem with this assumption is that what is legal and what is ethical do not always coincide. There are many breaches of ethical conduct about which the law is silent, and there might even be extreme situations in which to do what is legally mandated would constitute a breach of ethical conduct resulting in harm or injury to the service recipient. It is important to look at issues of law, but we must avoid reducing the question, "Is it ethical?" to the question, "Is it legal?"

Assumption 5: *Ethical standards governing clinical roles (e.g., psychiatrists, psychologists, social workers, nurses, addiction counselors) can be indiscriminately applied to the role of recovery coach.*
Fact: There are considerable areas of overlap between ethical guidelines for various helping roles, but ethical standards governing clinical work do not uniformly apply to the RC role. This potential incongruence is due primarily to the nature of the RC service relationship (e.g., less hierarchical, more sustained, broader in its focus on non-clinical recovery support service needs) and to its delivery in a broader range of service delivery sites.

Assumption 6: *Formal ethical guidelines are needed for recovery coaches in full-time paid roles but are not needed for recovery coaches who work as volunteers for only a few hours each week.*
Fact: Potential breaches in ethical conduct in the RC role span both paid and voluntary roles. The question recovery support organizations are now wrestling with is whether volunteer and paid RCs should be covered by the same or different ethical guidelines.

Assumption 7: *If a recovery coach gets into vulnerable ethical territory, he or she will let us know. If the supervisor isn't hearing anything about ethical issues, everything must be okay.* Fact: Silence is not golden within the ethics arena. There are many things that might contribute to such silence, and all of them are potential problems. The two seen most frequently are the inability of recovery coaches to recognize ethical issues that are arising and their failure to bring those issues up for fear it will reflect negatively on their performance. The latter is a particular problem where supervision is minimal or of a punitive nature. The best recovery coaches regularly bring up ethical issues for consultation and guidance.

CORE RECOVERY VALUES AND ETHICAL CONDUCT

Traditional professional codes of conduct for the helping professions have been heavily influenced by law and have also drawn heavily from medical ethics. In setting forth a model of ethical decision making and ethical guidelines for recovery support specialists, we sought to look, not beyond the recovery community, but within the history of American communities of recovery, from traditional Twelve-Step communities to religious and secular recovery communities. We drew two conclusions from that exercise. First, we noted the importance of group conscience within the history of particular communities of recovery and the likelihood that judgments of behavior would differ across these recovery communities. That suggested to us the importance of establishing a local council of people in recovery representing diverse recovery experiences that could offer collective guidance on ethical issues as they arise. Second, we looked across recovery traditions (religious, spiritual, and secular) and within the collective experience of organizations providing recovery support services and found a set of core values shared across these organizations. We felt that these values could provide a helpful filter for ethical decision making, and that it was important to evaluate actions of the recovery coach by these shared values rather than by the values of any one recovery community. These core values and the obligations we felt they imposed on those providing recovery support services are listed below.

- Gratitude & Service
  —Carry hope to individuals, families, and communities.
- Recovery
  —All service hinges on personal recovery.
- Use of Self
  —Know thyself; Be the face of recovery; Tell your story; Know when to use your story.
- Capability
  —Improve yourself; Give your best.
- Honesty
  —Tell the truth; Separate fact from opinion; When wrong, admit it.
- Authenticity of Voice
  —Accurately represent your recovery experience and the role from which you are speaking.
- Credibility
  —Walk what you talk.
- Fidelity

—Keep your promises.

- Humility
  —Work within the limitations of your experience and role.
- Loyalty
  —Don't give up; Offer multiple chances.
- Hope
  —Offer self and others as living proof; Focus on the positive—strengths, assets, and possibilities, rather than problems and pathology.
- Dignity and Respect
  —Express compassion; Accept imperfection; Honor each person's potential.
- Tolerance
  — "The roads to recovery are many" (Wilson, 1944); Learn about diverse pathways and styles of recovery.
- Autonomy & Choice
  —Recovery is voluntary: It must be chosen; Enhance choices and choice-making.
- Discretion
  —Respect privacy; Don't gossip.
- Protection
  —Do no harm; Do not exploit; Protect yourself; Protect others; Avoid conflicts of interest.
- Advocacy
  —Challenge injustice; Be a voice for the voiceless; Empower others to speak.
- Stewardship
  —Use resources wisely.

A PEER-BASED MODEL OF ETHICAL DECISION MAKING

A model of ethical decision making is simply a guide to sorting through the complexity of a situation and an aid in determining the best course of action that one might take in that situation. We propose that those providing recovery support services ask three questions to guide their decision making (Note: A worksheet on these questions is provided after the article, on Page 31).

Question One: Who has the potential to be harmed in this situation, and how great is the risk for harm? One answers this question by assessing the vulnerability of the parties listed in the table below and determining the potential for, and possible severity of, injury to each. Where multiple parties are at risk of moderate or significant harm, it is best not to make the decision alone, but to seek consultation with others, given the potential repercussions of the situation.

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

Question Two: Are there any core recovery values that apply to this situation, and what course of action would these values suggest be taken?

___ Gratitude & Service (Carry hope to individuals, families, and communities).
___ Recovery (All service hinges on personal recovery).
___ Use of Self (Know thyself; Be the face of recovery; Tell your story).
___ Capability (Improve yourself; Give your best).
___ Honesty (Tell the truth; Separate fact from opinion; When wrong, admit it).
___ Authenticity of Voice (Accurately represent your recovery experience and role).
___ Credibility (Walk what you talk).
___ Fidelity (Keep your promises).
___ Humility (Work within the limitations of your experience and role).
___ Loyalty (Don't give up; Offer multiple chances).
___ Hope (Offer living proof; Focus on the positive).
___ Dignity and Respect (Express compassion; Accept imperfection; Honor potential).
___ Tolerance ("The roads to recovery are many.") (Wilson, 1944)
___ Autonomy & Choice (Recovery is voluntary; it must be chosen).
___ Discretion (Respect privacy; don't gossip).
___ Protection (Do no harm to and protect self and others; Avoid conflicts of interest).
___ Advocacy (Challenge injustice; be a voice for the voiceless; empower others).
___ Stewardship (Use resources wisely).

Question Three: What laws, organizational policies or ethical standards apply to this situation, and what actions would they suggest or dictate?

In the next section, we will explore a wide variety of ethical dilemmas that can arise in the context of delivering recovery support services and illustrate how this three-question model can be used to enhance decision making.

ETHICAL ARENAS

Ethical issues can crop up in a number of arenas related to the delivery of peer-based recovery support services. In this section, we will present and discuss case vignettes to highlight such issues within five arenas: 1) service context, 2) personal conduct of the recovery coach**,** 3) conduct in service relationships, 4) conduct in relationships with other service providers, and 5) conduct in relationships with local recovery communities. The vignettes and discussion were developed in consultation with the PRO-ACT Ethics Workgroup and other organizations delivering recovery support services. The responses to the vignettes are not intended to generate rules for behavior; they are intended to convey the evolving sensitivities on key ethical issues within the growing recovery support services movement.

SERVICE CONTEXT

Exploitation of Service Ethic: Agency ABC visibly promotes itself as providing peer-based recovery support services, but the agency's reputation is being hurt by key practice decisions.

- ABC hires people as recovery coaches who have minimal sobriety time.

  The legitimacy of each RC is derived from experiential knowledge and experiential expertise. Where there is little or no experience, there is no legitimacy. Recovery coaches should be hired only if they have established personal programs of recovery marked by duration and quality. Minimum recovery requirements for recovery coaches are currently ranging from one to two years, with many recovery coaches possessing more than five years of continuous recovery. This minimum requirement is for the protection of those receiving, and for the people and organizations providing, recovery support services.

- ABC does little to orient, train, or supervise their recovery coaches.

  Failure to provide RCs with the needed orientation, training, and supervision affects their capabilities, their credibility, and the safety of both the RC and the person receiving recovery support services. The quality of screening, training, intense initial supervision, and ongoing supervision constitute the foundation for the delivery of effective and ethical recovery support services. The delivery of RC services, particularly volunteer-based RC services, requires more supervision than clinical services provided within an addiction treatment context, because non-clinical recovery support services often lack some of the mechanisms of protection built into the delivery of treatment services, e.g., prolonged training and credentialing, a formal informed consent process, and office-based service delivery. Developing clear policies governing the delivery of recovery support services, and establishing monitoring procedures to oversee the delivery of those services, also can help ensure that the delivery of RC services will be covered within the sponsoring organization's liability/malpractice insurance.

- ABC pays recovery coaches a pittance while asking them to work excessive hours that often interfere with their own recovery support activities.

This practice constitutes a form of financial exploitation of recovering people that contributes to RC burnout, high RC turnover, and erosion in the quality of recovery support services. Providing adequate support for volunteers, paying adequate salaries, offering advancement opportunities for RCs in paid roles, and setting limits on hours worked for both volunteers and paid support specialists are crucial steps in sustaining the quality of peer-based recovery support services.

- ABC assigns volunteer recovery coaches to perform counselor functions, then bills for these services.

  This practice is a breach of ethical principles (honesty & fidelity), a breach of law, and a practice that violates the integrity of both the counselor role and the RC role. RCs are not cost-free labor; substantial expense should be incurred in the infrastructure to support volunteer recovery coaches via recruitment, screening, selection, orientation, ongoing training, ongoing supervision, and events celebrating the service work of RC volunteers.

- ABC assigns recovery coaches to work in isolation, delivering home-based services in drug- and crime-saturated neighborhoods.

  RCs assigned to home-based services, particularly those delivering pre-treatment engagement and support (outreach) services, need elevated supports to counter the particular stressors inherent in this role. Such supports include special training related to safety management, team-based service delivery (co-coaching), technical supports (cell phones, two-way radios), neutral sites for meetings in high-risk neighborhoods, etc.

- ABC uses recovery coaches almost exclusively to recruit clients into treatment.

  This practice, when it involves using the RC role to "fill beds" or outpatient "slots," constitutes an exploitation of the RC role for the financial benefit of the organization. It reflects poor stewardship of the RC resource by displacing the recovery support needs of clients for the financial interests of the organization.

Screening Practices: DEF is a grassroots recovery advocacy organization that provides recovery coaching services through a cadre of volunteers from the recovery community. Today, a man notorious for his predatory targeting of young women entering NA arrives at DEF announcing that he would like to volunteer as a recovery coach. How should DEF respond to this request?

The screening of volunteers and staff for recovery support roles is designed in part to protect the hiring agency and its service constituents. This protection function must be ensured, and at the same time the agency must practice standards of fairness in its selection procedures, e.g., not excluding someone based only on second-hand gossip. Selection for RC roles is unique in that a past addiction-related felony conviction (followed by a long and stable recovery career) might be viewed as more a credential than grounds for disqualification. On the other hand, a history of and reputation for exploitive behavior within the recovery community might be grounds for disqualification. The purpose of such disqualification would be the protection of service recipients and the protection of the reputation of the recovery support organization, e.g., ensuring that people feel safe and comfortable seeking services at the organization. White and Sanders (2006) describe how the credential of experiential expertise is established:

Experiential expertise is granted through the community "wire" or "grapevine" (community story-telling) and bestows credibility that no university can grant. It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships, and performance within the community (White & Sanders, 2006, p. 69).

The community wire can withhold as well as bestow the credential of experiential expertise, and it can grant such expertise with conditions, e.g., using the individual in the above role as a closely supervised RC, but only with men.

PERSONAL/SERVICE CONDUCT

Self-Care: Jerome brings great passion to his role as an RC, but models very poor self-care. He is overweight, smokes excessively, and has chronic health conditions that he does not manage well. To what extent are these ethical issues related to his performance as a recovery coach? What is the nexus between such private behaviors and Jerome's performance as an RC?

Private behavior of the RC is just that—private, UNTIL there is an inextricable nexus (link) between private behavior and one's performance as a RC. In this case, Jerome's poor self-care does potentially impact his effectiveness as a RC. The expectation here is not one of perfection, but one of reasonable congruence between one's espoused values and the life one is living. In this case, Jerome is modeling potentially lethal behaviors that those he coaches may well integrate into their own lifestyles, e.g., "It is okay for me to smoke because Jerome smokes." Part of the job of the RC is to make recovery attractive—to make recovery as contagious as addiction in the local community. To become a recovery coach requires being, not only a face and voice of recovery, but also a person whose character and lifestyle others would choose to emulate. Our ability to achieve that is enhanced by self-care training that is built into the overall RC orientation and training program.

Personal Impairment: Mary has functioned as an exceptional RC for the past two years, but she is currently going through a very difficult divorce. The strain of the divorce has resulted in sleep difficulties, a significant loss of weight, and concern by Mary about the stability of her sobriety and sanity. When do such events in our personal lives become professional practice issues? What should Mary and her supervisor do in response to these circumstances?

Again, events in our personal lives are of concern when, and only when, they ripple into our performance in the service arena. All of us undergo developmental windows of vulnerability that require focused self-care and temporarily diminish our capacities for service to others. Mary and her supervisor need to consider what would be best for her, for those she coaches, and for the agency. One option is for Mary to decrease her hours or number of people served and to have increased supervisory or peer support (e.g., team coaching) for a period of time. Another option would be for Mary to take a sabbatical to focus on getting her own health back in order. For Mary to raise this issue in supervision is not something to be ashamed of, but the mark of service excellence—

making sure that our own periodic difficulties do not spill into the lives of those we are committed to helping.

Lapse: Ricardo, who has worked as an RC for more than a year, experienced a short lapse while attending an out-of-town wedding. Because the lapse was of such short duration, Ricardo plans not to disclose the relapse to the organization through which he provides RC services. What ethical issues does this situation raise? What should Ricardo do? What should be the organization's/supervisor's response if this situation is brought to his or her attention? What organizational policies must be established to address the issue of lapse/relapse?

There are several core values that apply to this situation, e.g., honesty, credibility, primacy of recovery. All of these values suggest a course of action that would begin with Ricardo's disclosure of the lapse to his supervisor and focusing on re-establishing the stability and quality of his personal recovery program. The organization should rigorously follow the guidelines/protocols it has established to respond to such an event. Options might include Ricardo's taking a break from his RC responsibilities, performing activities that do not involve direct coaching responsibilities, and later phasing back into RC responsibilities via co-coaching and more intensive supervision.

Personal Bias: Zia has many assets that would qualify her as an excellent RC, but in interviewing her for an RC position, you are concerned about one potential problem. Zia passionately believes that AA's Twelve Step program is the ONLY viable framework of long-term addiction recovery, and she expresses considerable disdain for alternatives to AA. What ethical issues could arise if Zia brought her biases in this area into her functioning as an RC?

*The core value of tolerance asserts the legitimacy of and respect for diverse pathways and styles of long-term recovery. Bill Wilson (1944) was one of the first advocates of such diversity. If Zia cannot develop such tolerance, she may be better suited to the service role of sponsor within a Twelve Step program than to the role of an RC who works with multiple programs of recovery. The same principle would apply to those using recovery programs other than the Twelve Steps who believe there is only one true way to recovery, or who have antipathy toward one particular program. What we know from research on recovery is that ALL programs of recovery have optimal responders, partial responders, and non-responders (*Morgenstern, Kahler, Frey, & Labouvie, 1996). T*raining and exposure to people in long-term recovery representing diverse recovery pathways can be used to promote tolerance for multiple pathways of recovery.*

Pre-existing Relationships: Barry's supervisor has assigned a new contact for Barry to visit in his RC role. Barry recognizes the name as a person to whom Barry once sold drugs in his earlier addicted life. Who might be harmed in this situation? What should Barry do? Does Barry have a responsibility to report this pre-existing relationship to the supervisor?

Multiple parties may be at risk here: Barry, his contact, the contact's family, and Barry's agency. Barry should disclose the relationship and request another assignment. If the only alternatives are Barry or no services (e.g., a situation in which Barry might be the only recovery coach in the community), Barry and his supervisor should explore additional options or explore how they might ensure that these RC services are provided and still minimize harm to all parties. The most critical factor here is the need to maximize the comfort and safety of the individual/family receiving services. It is best if RCs are expected to declare immediately any pre-existing relationships with those to whom they have been assigned.

Use of Information Across Roles: Rebecca is a natural listener. Everyone talks to her—in her RC role and outside her RC role. Rebecca is also very active in the local Twelve-Step community. Today, a person Rebecca is coaching mentions the name of a new boyfriend whom Rebecca recognizes as a man with whom one of her sponsees is involved. The relationship between the sponsee and this man has been a major source of sabotage to the sponsee's recovery, and the sponsee also contracted an STD from this man. Can Rebecca use information gained from roles in her personal life in her role as an RC? How should she handle this situation?

> *This vignette generated considerable disagreement among the recovery support agency representatives who reviewed it. Opinions split into two camps. The first group suggested that Rebecca could, and had a duty to, disclose this information as long as it was judged to be reliable and as long as no anonymity was violated related to the disclosure. The other camp took the position that disclosing this information would violate AA etiquette ("What's said here, stays here"), that it was not Rebecca's role to disclose this information, and that Rebecca needed to stay supportive through whatever unfolded within this relationship. A good general guideline is: moving information from one role into another role (e.g., using information gained at a Twelve-Step meeting into one's RC activities) is fraught with potential harm and should be brought into supervisory discussion before such information is used in this manner.*

Advocacy: Many RCs are also involved in recovery advocacy activities in their local communities. Are there any situations that might arise in one's advocacy role that could conflict with one's role as an RC? Could any of these situations involve potential harm to others?

> *This would depend on the nature of the recovery advocacy activities. There are many recovery coaches who are also very much involved in the new recovery advocacy movement who experience minimal conflict in these roles. Conflicts could arise if the recovery advocate/coach:*
>
> - *used the RC context to zealously recruit those whom he or she coached into advocacy activities;*
> - *used the RC role to push particular ideological propositions; or*
> - *took such extreme, controversial positions that individuals and families were not comfortable having the individual serve as their RC.*
>
> *Such potential conflicts are best processed with one's supervisor.*

Conflict of Interests: Raphael works as a recovery coach and also owns a recovery home. In his RC role, Raphael frequently encounters people who need sober housing. What ethical issues could arise from Raphael's referral of people to the recovery home that he owns? How might Raphael best handle any real or perceived conflicts of interest? What organizational policies address the issue of conflicts of interest?

> *Referring clients to his own recovery home raises potential conflicts between the client's best interests and Raphael's own financial interests. Even the PERCEPTION of bias relating to this linkage process might injure Raphael's reputation as an RC and the reputation of the organization for which he is working. Raphael would be better advised to refer his clients to other recovery homes or to offer a list of all available resources*

without any accompanying interventions that would direct individuals to his own facility. In addition, Raphael may want to assign a "manager" to do all screening for potential residents to his home, so that he not only doesn't refer his own clients, but also doesn't make decisions related to their entrance. At a minimum, Raphael will want to make sure that those he serves always have a choice of resource options and that he does nothing to steer people toward institutions in which he has a financial interest.

Role Integrity: Marcella is in long-term recovery, works as a volunteer recovery coach, and also works full time as a certified addictions counselor. What problems might be posed by Marcella's bringing the clinical orientation from her counselor role into her volunteer role as a recovery coach? How can the organization/supervisor help "counselors as peers" suspend their clinical orientation while they are functioning in their RC roles?

The potential problems in this situation are numerous. First, if Marcella drifted into her counseling role while performing volunteer service, she would be providing counseling without the client protections and supports built into traditional treatment agencies, e.g., informed consent, legal confidentiality, clinical documentation, clinical supervision, and agency liability insurance. Assuming Marcella's client is still in treatment, the therapy Marcella provides may be counterproductive to the therapy the client is already receiving. And perhaps most important: during the time in which Marcella is doing counseling, the client is not receiving needed recovery support services.

Compassion Fatigue: Elizabeth has volunteered as an RC for the past 2½ years, supporting the recovery processes of individuals with very severe, complex, and long-term substance use disorders. In recent months, she has noticed that she is bringing less energy and enthusiasm to her volunteer work and is dreading seeing some of those with the greatest needs. How should Elizabeth respond to this diminished motivation for recovery coaching?

The danger here is a process of emotional and physical disengagement that could do a great disservice to those in need of recovery support services. Elizabeth is exhibiting signs of burnout, which must be acknowledged and addressed in supervision. Elizabeth may need a break in her coaching activities, might consider reducing her hours, might need to work with people who have lower levels of problem severity for a while, or might want to consider co-coaching for a period of time. It might also be a good time for Elizabeth to refresh her stress-management skills via training or her own personal coaching. Those volunteering as recovery coaches need the option of taking sabbaticals from this service work, but they also have a responsibility to recognize this need early enough to plan an orderly transition or termination process for those with whom they are working. Both precipitous disengagement and a failure to disengage when disengagement is indicated present potentials for harm to those receiving recovery support services.

CONDUCT IN SERVICE RELATIONSHIPS

Choice/Autonomy: Charise works as a recovery coach in a women's program that is known for its assertive—some would say aggressive—style of outreach to women referred from the child welfare system. The women Charise attempts to engage in treatment and recovery support services are very ambivalent in the early stages of engagement—not wanting to see her one day, thrilled to see her the next. The questions are: "When does 'NO' really mean 'No'?" What

is the line between assertive outreach and stalking? How do we reconcile a person's right to choose with the knowledge that volitional will is compromised, if not destroyed, through the process of addiction?

> *The ethical tension here is between the values of autonomy and choice versus paternalism and outright domination. What complicates any resolution of this tension is the fact that we are working with people who by the definition of their illness (addiction) have compromised capacities for free choice, leaving the RC questioning whose free choice they should listen to—Dr. Jekyll's or Mr Hyde's. In short, what do we do with someone who one moment wants recovery and the next minute wants to get high? The answer is that we recognize that addiction is a disease of the will and that recovery involves a progressive rehabilitation of the will. The RC's job—particularly in the outreach function—is to jumpstart motivation for recovery where little exists, and to guide people through the early stages of recovery until they can make choices that support their own best interests. At a practical level, this means that "no" ("I don't want you to contact me anymore") has to be said several times to different people on different days before we give up on someone (for the time being). If after a reasonable period of time, the answer is still "no," then we disengage with the assurance that we will be available in the future if the person should CHOOSE to call us. The proposition that recovery is voluntary means, not only the freedom to choose different pathways of recovery, but also the freedom to choose not to recover.*

Choice/Autonomy: Roberto has been assigned as a recovery coach for Oscar, but four weeks into this process, Oscar requests a change in recovery coaches on the grounds that he is having difficulty relating to Roberto. Do those receiving RC services have the right to select their own recovery coach?

> *Mismatches in the assignment of recovery coaches are inevitable, just as mismatches occur in the assignment of counselors. A match between a recovery coach and someone whom he or she serves may be even more important because of the increased time spent together and the potential duration of the relationship. The occasional mismatch is best acknowledged early and resolved either through alterations in coaching style or through reassignment to a new recovery coach. The affects of recovery coaching result from personal influence, not from any power or authority ascribed to the role. An essential principle of peer-based recovery support services is that those receiving the service ultimately get to define who qualifies as a "peer." Evaluating and resolving potential mismatches is an integral part of good supervision. It is also important that RCs be supported through these situations.*

Emotional Exploitation: John is a highly sought-out RC. He is charismatic and unrelenting in his support activities. As his supervisor, you have one area of concern about John: he is emotionally possessive of those he works with, hypercritical of other service providers who don't live up to his standards, and competitive with the sponsors of those he coaches. Many of those John serves do very well in their recovery, but they seem to see the source of their recovery as John more than a program of recovery. You are troubled that those John works with seem to have developed an excessive emotional dependency in their relationship with him. What ethical issues are raised by this situation?

> *There are several core values that apply to this situation, e.g., humility, respect, tolerance, autonomy, capability. The style described above, by cultivating dependence and emotionally rewarding crises, actually weakens people's future capacity for self-*

sustained recovery. Those served end up feeling progressively better about John, but worse about themselves. Such a style may meet John's needs, but it ill serves those he coaches. Such styles harm clients, overshadow other RCs who may be doing much more effective service work, and often end up harming the community agency's credibility in the long run. A degree of dependence is normal early in the RC relationship, but such dependence is best transferred to the development of a larger and more sustainable sobriety-based support network.

Friendship: Raymond volunteers as a recovery coach for a recovery community organization (a freestanding organization, unaffiliated with any treatment organization, that provides recovery support services). Raymond shares a lot in common with Barry, a person to whom Raymond has been assigned to serve as a recovery coach. Over a period of months, Raymond and Barry have developed quite a friendship and now share some social activities (e.g., fishing) beyond the hours in which Raymond serves as Barry's recovery coach. Are there any ethical issues raised by this friendship?

Friendships may develop within the context of recovery coaching, but there is one thing that distinguishes the recovery coach relationship from other social relationships, and that is the service dimension of that relationship. This means that recovery coaching relationships are not fully reciprocal, whereas friendships are. The RC has pledged that the focus of the RC relationship is on the needs of the person being coached. In that light, ethical problems could arise if: 1) the friendship were initiated by Raymond to meet his needs and not Barry's needs, 2) problems in the friendship interfered with Raymond's ability to provide effective coaching services, or 3) the friendship with Raymond prevented Barry from developing other sobriety-supportive relationships within the recovery community and the larger community. RC relationships will, by definition, be less hierarchical and more reciprocal than will relationships between an addiction counselor and his or her client. It's not that one boundary demarcation is right and the other is wrong; what is important is that boundaries are maintained that are role-appropriate. In other arenas of peer-based services, their effectiveness has been attributed in great part to the lack of professional detachment and distance (Fox & Hilton, 1994). Where a developing friendship is getting in the way of effective RC services, it is the responsibility of the RC to raise this concern with his or her supervisor, and possibly to review this situation with the RC, the supervisor, and the client. One potential option is to assign and transition the client to another RC, to avoid potential problems stemming from the dual relationship.

Sexual Exploitation: You supervise recovery coaches for a local recovery advocacy and support organization. It comes to your attention that Joshua, one of your RCs, is sexually involved with a person to whom he is delivering recovery support services. What are the ethical issues involved in this situation? How would these issues differ depending on: 1) age or degree of impairment of the person receiving services? 2) whether this was a person currently receiving or a person who had previously received recovery support services? 3) the time that had passed since the service relationship was terminated? Would you view this situation differently if the relationship were not with the primary "client" but with a family member or friend who was involved in the service process? Could the recovery coach or the agency face any regulatory or legal liabilities related to this relationship?

The RC service relationship is not a relationship of equal power. The vulnerability of those seeking RC services and the power of the RC role offer situations in which an RC might exploit service relationships for his or her personal, emotional, sexual, or financial

gain. It is that power discrepancy that makes intimate relationships between RCs and those with whom they work with ethically inappropriate. The harm that can come from such relationships spans injury to the person/family being served (emotional trauma, severance of services, resistance to seeking future services), injury to the reputation of the RC, and damage to the reputation and financial solvency of the service organization (via litigation against the organization for improper hiring, training, supervision, etc.). The prohibition against an intimate relationship between an RC and service recipient also extends to members of the service recipient's family and intimate social network who are involved in the service process. As for relationships with people who previously received RC services, agencies are defining a period of time (mostly in the two-year range) in which such relationships would still be improper. The key here is to evaluate situations that might arise based on the issue of exploitive intent. For example, an RC might be involved with an individual he or she met within the recovery community who he or she discovers once received RC services from the RC's organization. The RC did not work at the organization at the time, never served as the person's RC, had no knowledge of the person's status as a service recipient, and did not use the influence of his or her RC role and organizational affiliation to initiate the intimate relationship. In short, there was no exploitive intent.

Financial Exploitation: Alisha is providing RC services to a very socially prominent and wealthy individual and his family. She has repeatedly turned down the family's offers of money for her services and communicated that her services are provided through a federal grant and are available to all local citizens without charge. It has casually come up in conversations that Alisha is saving money to begin taking courses at the local community college. When Alisha arrives for her visit today, the family announces that they have discussed it among themselves and that they want to pay Alisha's tuition to return to college. What should Alisha consider in her response to this offer?

Money changes relationships. Accepting this gracious offer would threaten the integrity of the coaching relationship. Alisha should express her appreciation for the family's offer, but explain that she must decline because acceptance of this gift while the recovery coaching is in process could affect that relationship. The family's feelings can be further protected if Alisha can inform them that there is an agency policy that prevents any RC from accepting any gifts of substantial value. The situation might be viewed differently if some time after the service relationship was ended, the same family wanted to donate money to Alisha's education or to the service organization. The key here is that the vulnerability or gratitude of the family is not used in an exploitive manner. All offers of gifts to an RC during or following a service relationship should be discussed with the supervisor.

Gifts: Marie works as an RC in an addiction treatment unit within a local community hospital. Her job is to provide recovery support services to those discharged from addiction treatment. She serves a predominately Native American population and conducts most of her work via home visits on two reservations. When she arrives for one of her visits today, the family she is visiting presents her with an elaborate, culturally appropriate gift as a token of their appreciation for her support. The problem is that Marie works in a hospital whose personnel code prohibits any staff member from accepting a personal gift. Marie is concerned about the consequences of accepting the gift, but is also concerned that refusal of the gift could harm her relationship with the family and the tribe. What are the ethical issues here? What should Marie do?

Ethical decision-making must be culturally grounded. What this means is that the pros and cons of any action must be evaluated in the cultural context in which it occurs. What might be unethical in one cultural context (e.g., accepting a gift) might in another be, not only ethical, but also essential in maintaining the service relationship. In this case, Mary could accept the gift in the name of the hospital, protecting herself from the hospital policy and leaving the RC relationship intact. Mary could report the gift to her supervisor and display the gift in a common area of the hospital for all to enjoy. What would be equally appropriate would be for Mary to raise the broader issue of the need for more flexible interpretations of this particular policy when working in this tribal context. Ironically, a policy designed to protect patients might actually result in injury to patients, severance of the service relationship, and damage to the reputation of the service institution. RCs working across cultural contexts need policy flexibility and good supervision to protect the service relationship.

Boundaries of Competence: During a visit today with Camella, a person you are coaching, she asks you what you think about the effects of anti-depressant medications on recovery from alcoholism. She is clearly ambivalent about the medication she is being prescribed, and your first inclination is to tell her to forget the medication and get to more meetings. What are the ethical issues in this situation? How would you respond?

It is quite appropriate for the RC to listen to Camella's concerns about her medication, encourage her to talk to her physician about these concerns, and link her to resources to get additional information about recovery and anti-depressant medications. It is not appropriate for the RC to offer his or her opinion or advice about any prescribed medication. To do so would be to move beyond the boundaries of the RC's education, training, and experience. Even if the RC were a physician volunteer, his or her responsibility in the RC role would be to link Camella to medical resources she could consult about this question, rather than to provide that information directly. Under no circumstance should an RC ever advise anyone to stop taking a prescribed medication. If the RC has concerns about the effects of particular medications on Camella's recovery (e.g., prescribed sedatives or narcotic analgesics), the RC's role is to link Camella to someone with expertise, e.g., a physician trained in addiction medicine, to discuss these issues.

When to Refer: Martha has attempted to engage Rita in the recovery coaching process for the past five weeks, but the chemistry between the two of them seems to have gone from bad to worse. All efforts to work through these difficulties in supervision have failed to improve the situation. At what point should Martha acknowledge this situation to her supervisor and Rita and seek to have another recovery coach assigned to Rita?

The value of honesty dictates that Martha acknowledge to Rita and to Martha's supervisor her concerns about the relationship difficulties, and that she raise the question of whether or not Rita would be better served with a new RC. She should raise this question with the supervisor, and if efforts to improve the relationship fail, then a meeting between Martha, Rita, and the supervisor may be in order. The agenda is to avoid harm to Rita from a relationship mismatch, to establish an effective coaching relationship, but to also avoid any feelings of abandonment that Rita might experience by the suggestion of a new RC.

Discretion: Maria serves as an RC for women and their families who are participating in a local women's treatment program. Maria frequently hears from those she coaches, "I want to tell you

something, but you can't tell my family" or "I want to tell you something important about Jennifer, but I don't want you to tell her I told you." What ethical issues are raised when the RC is placed in the middle of these types of communications? How should Maria handle such communications?

> *It is essential to establish communication ground-rules at the beginning of the RC relationship. The values of discretion, respect, and fidelity demand that the RC not disclose information beyond the established ground-rules. Those ground-rules include review of circumstances in which disclosures will be made, e.g., supervision, medical emergencies, or imminent threat of harm to self or others. Before deciding whether or not to agree to the requested promises described above, Maria should again review those communication ground-rules and the disclosure exceptions.*

Discretion versus Duty to Report: A person for whom you are serving as recovery coach discloses to you that he has been using during the past week with another person who lives with him in a local recovery home. The disclosure makes it clear that the other person provides the drugs used and may be dealing in the home and in the larger community. Further complicating the situation is the fact that the owner of the recovery home is a member of your board of directors. Do you have an ethical responsibility to protect this disclosure or to report the content of the disclosure to the house manager or the owner of the recovery home? Would a recovery coach have a similar obligation to report the presence of a "script doctor" who was pumping massive quantities of prescription opiates into the community—when the source of that information was one of those he or she was coaching?

> *Such information could not be ethically reported without permission for such disclosure. In both cases, the RC could discuss with the disclosing individual whether or not that individual thought the information should be conveyed to responsible authorities, if the individual was comfortable making such a report, or if he or she would want the RC to make such a report without disclosing his or her identity as the source. Using this process would address the threat to the recovery home environment or the community without violating the promise of confidentiality.*

Threat to Community: When you arrive for a home visit with Joe Martin, a person you are coaching, you find him intoxicated. Joe says he can't talk to you right now because he has to return to the bar he just left to pay off a debt. Joe has his car keys in his hand. What do you do?

> *Use all of your persuasion skills to keep Joe out of the car. Ask Joe to give you the car keys, and let him know that, if he gets in the car, you will have no recourse but to call the police. If he gets in his car and drives away, call the police, informing them that you observed an intoxicated man by the name of Joe Martin getting into a car, and provide the vehicle description and location. Do not identify yourself in your service role, and do not identify Joe as a service recipient of the organization. The challenge here is to address the threat to public safety without disclosing Joe's status as a service recipient.*

Personal Bias: Fred has worked hard to educate himself about medication-assisted recovery since he was first hired as an RC, but he still has very negative feelings about methadone in spite of the research literature he has read about it. It's not a "head thing"; it's a "gut thing." Marcy, another RC, has similarly negative feelings about explicitly religious pathways of recovery because of the number of people she has known in AA for whom religion alone did not work as a framework for recovery. Describe how the personal biases of the RC might result in

harm or injury to multiple parties, and how that harm might be avoided. For example, how might Fred separate the scientific facts about methadone from his feelings (opinions) about methadone?

> *As individuals, we may have all manner of biases about different addiction treatments, but in the RC role, we have a responsibility to outline the choices available to those we serve as objectively as possible and support each person's choice of the option that seems best for him or her at this moment. Discouragement of a particular method of treatment may prevent a client from getting the "one" treatment method that might be most successful. Fred and Mary should continue to acknowledge and discuss their biases with their supervisor. Fred and Mary may not need more information and training on alternative treatments and pathways to recovery as much as they need direct contact with people who have successfully used these methods to achieve long-term recovery. As experiential learners, many RCs won't credit the research findings until they experience this evidence face-to-face.*

CONDUCT IN RELATIONSHIPS WITH OTHER SERVICE PROVIDERS

Responding to Unethical Conduct: Susan, a person for whom you have been serving as an RC for the past month, discloses to you today that she is in a sexual relationship with the counselor she is seeing at a local addiction treatment agency. The counselor is a very prominent person in the local recovery community and is very active in the state addiction counseling association. What ethical issues does this situation present? How would you respond?

> *This situation raises several needs. The first is to acknowledge to Susan that such a relationship is a breach of the counselor's professional ethics, and to ask if she wants a referral to a different treatment agency, and if she wants to file a formal complaint with the state counselor certification board or seek other legal redress. Linking Susan to such resources would be a natural RC function, as would supporting Susan through this process. Depending on the policies of your agency, you may also let Susan know that you will need to report this disclosure to your supervisor, who may also be bound to report it to the state certification board, either with Susan's name or without it. All reports of ethical breaches by other service professionals in the community that come to the RC's attention should be communicated to the RC's supervisor.*

Representation of Credentials (Example 1): Samuel works as a recovery coach, doing post-treatment telephone monitoring. In his interactions with the larger community, Samuel has represented that he is working as a "counselor." He also makes periodic mention of his plans to "get back" to graduate school," but Samuel has only completed two years of college and has not been in school for more than ten years. What ethical issues does this situation raise?

> *The values of honesty and credibility call upon the RC to accurately represent his or her education, training, and experience. The supervisor should acknowledge that he or she has heard the above reports and emphasize why it is important that, if the reports are true, these communications stop and be replaced with an accurate description of Samuel's role and educational credentials. This might well be accompanied by a broader discussion of how RCs establish credibility and legitimacy within the larger service community.*

Representation of Credentials (Example 2): Would you view Samuel's situation any differently if he accurately represented his role and education, but misrepresented the length of his own recovery and his degree of current involvement in AA, NA, or another recovery mutual aid group?

> *No, both would undermine his capability and credibility as an RC. The value of authenticity of voice is paramount here. The following guideline is recommended: "Filter decisions related to disclosure of your ATOD use history, your recovery status, and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth); discretion (protect your privacy); and, for those in Twelve Step recovery, the tradition of anonymity at the level of press" (White, 2006b).*

Role Clarity/Integrity: George has worked as Larry's RC for the past two months. Today, Larry asks George if George would be his NA sponsor. George has a long history in NA and a long history of sponsorship activities, but agreeing to this arrangement would mean that he would be both Larry's RC and his sponsor. What harm and injury (if any) might result from such a dual relationship, and who might be harmed?

> *Failure to maintain boundary separation between the roles of RC and sponsor might harm Larry, George, others receiving RC services, the relationship between George's organization and the local recovery community, and the larger community. The effect of dual relationships is often to "water down" both relationships. Here are some suggested operating principles (Excerpted from White, 2006c).*
>
> 1. *Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) on time in which one is working as an RC is a violation of Twelve-Step Traditions and professionally inappropriate (beyond the scope of most agencies' RC job descriptions and explicitly prohibited in many).*
> 2. *Performing sponsorship functions through the RC role could weaken local sponsorship practices and diminish community recovery support resources, by replacing such natural support with the formal support of local treatment agencies.*
> 3. *Seeking reimbursement for sponsorship functions performed by a recovery coach is, at best, a poor stewardship of community resources and, at worst, fraud.*
> 4. *Role ambiguity and conflict resulting from the mixing of sponsorship and RC functions might inflict injury on clients/families, service workers, service agencies, and the community.*
> 5. *The RC role represents a form of connective tissue between professional systems of care and indigenous communities of recovery, and between professional helpers and sponsors. When those filling this role abandon this middle ground and move too far in one direction or the other, that connecting function is lost.*

CONDUCT IN RELATIONSHIPS WITH LOCAL COMMUNITIES OF RECOVERY

Role Clarity/Integrity: George, who is a salaried RC, has a practice of linking those he coaches to recovery communities by taking them to, and participating with them in, particular recovery support meetings. A complaint has come to the agency about George's "getting paid" for the time he is in meetings, with the charge that this constitutes accepting money for Twelve-Step work. What are the ethical issues here? How might George more clearly delineate his paid activity from his NA service work?

The values of stewardship require that the RC carefully allocate his or her time. George should be careful to separate RC hours from hours spent in recovery support meetings so as not to receive payment for meeting time. The RC function stops at the doorway of recovery support meetings: George should introduce his client to other recovery support group members and "hand him off" for Twelve Stepping.

Discretion (Example 1): You are working as a recovery coach attached to a treatment agency. You take an assigned client, Troy, to a local recovery support meeting, and you stay for the meeting. At the meeting, Troy discloses information that he has not told his counselor at the treatment program. Is this information you have heard considered confidential, or do you have an obligation to report it to the counselor?

The information disclosed at the meeting may not be revealed outside the meeting. To do so would violate recovery mutual-aid values and place the RC in the role of "undercover agent" at such meetings. You can encourage Troy to take the information to his counselor. This is another example of the strong need for ongoing supervision and support to help the RC deal with complex issues regarding his or her role.

Discretion (Example 2): Claude has been in and out of treatment and NA multiple times and has an off-and-on-again relationship with you as a recovery coach. Today you run into Rudy, one of Claude's former NA sponsors with whom you collaborated, in the mall. Rudy's first comment to you is, "How's our boy doing?" How do you respond? Would this be an appropriate disclosure or simply gossip? Do the confidentiality guidelines that cover treatment relationships (and which would prohibit any disclosure in answer to Rudy's question) extend to the recovery coach relationship?

If you are in an organization covered by federal confidentiality regulations (e.g., a treatment agency), you may not respond to that question, or even acknowledge that Claude is a client at your organization, unless you have a release signed by Claude specifying that you may speak to Rudy about him. If you are in an organization not covered by federal confidentiality regulations (e.g., a free-standing recovery support organization, a recovery ministry within a church), your response should be guided both by your organization's policies on confidentiality and discretion and by the agreement about permitted disclosures of communications that you negotiated with Claude at the beginning of the RC relationship. The key thing here is the value of fidelity: to keep our promises.

Anonymity: Ernest is a long-time AA member, recovery advocate, and recently hired recovery coach. In his earlier recovery advocacy work, Ernest has always been very careful in identifying himself publicly as a "person in long-term recovery," without noting his AA affiliation. Today, Ernest is on a panel at a local social service conference to talk about the pilot recovery coaching project in which he works. The conference is being covered by local media, who ask to interview Ernest after the panel. One of the reporters follows up Ernest's report of his recovery status and its duration with the question, "Are you a member of AA?" What are the ethical issues involved in this situation? How should Ernest respond? How would this be different if Ernest was in an alternative recovery support group that did not have a tradition of anonymity?

Ernest should NOT disclose his membership in AA. This would violate AA's anonymity tradition and might be viewed as a personal endorsement of a particular mutual-aid group. Such a disclosure and the potential controversy spawned by it could interfere with Ernest's service relationships, isolate Ernest from the local AA community, and harm the relationship between Ernest's organization and the local AA community. If Ernest were not in AA or another Twelve Step program, there would be no explicit anonymity guideline, but Ernest would still need to be cautious in any disclosures at the level of press.

Predatory Behavior: Felicia works as a recovery coach for women who are just entering intensive outpatient treatment and living in a women's recovery home. One of Felicia's responsibilities includes linking these women to local recovery mutual-aid meetings. Many of the women Felicia works with have histories of sexual victimization as well as long histories of toxic intimate relationships. Felicia is aware that predatory behavior ("Thirteenth Stepping") is common in some local recovery meetings. To what extent is Felicia responsible for preparing the women she refers for such behavior or protecting them by linking them to meetings with a strong group conscience?

Felicia needs to honor the potential of her clients to be harmed in groups with little "group conscience." She should assist her clients in finding meetings with a "climate" that is safe and supportive.

Potential Iatrogenic Effects of Recovery Coaching: Ellen, a highly respected elder in the local AA community, is expressing criticism of recovery coaches and the broader recovery support services offered by a local recovery advocacy agency. It is Ellen's position that such roles and services will undermine the importance of sponsorship and weaken the service ethic within the local recovery community. How do you respond?

Ellen should be invited to discuss her views on recovery coaching and shown the statistics and local experience related to the role of recovery coaching in successful long-term recovery. You should also solicit ideas from Ellen about how the recovery coach's role might be designed and supervised to ensure that it enhances rather than undermines the service ethic within the local AA community.

Role Integrity: Mel is an elder statesman in AA who offers to volunteer as a recovery coach. Mel's orientation to coaching is to do what he does as a sponsor: help people work the steps and develop a life of sobriety and serenity. What harm, if any, could come from this merger of the sponsor and recovery coach roles?

The primary harm in this merger of RC and sponsor roles would come from the broader recovery-support needs (e.g., sober housing, medical needs, transportation, day care) that would be addressed in the fully developed RC role but not addressed in the RC-as-sponsor role. Harm to the client could also result from the confusion between the RC and sponsor roles.

SUMMARY

This essay has described a model of ethical decision making for recovery coaches and their supervisors and identified some of the emerging ethical issues in the delivery of peer-based

recovery support services. Ethical sensitivities and approaches to ethical decision making will continue to evolve as recovery support services become more formalized and the collective experience of recovery coaches and their sponsoring organizations grows. This growing foundation of experience will spawn formal ethical guidelines for recovery coaches and more formal approaches to ethical decision-making. PRO-ACT has created a peer services ethics advisory panel and a set of ethical guidelines for its peer specialists that we expect will become more refined in the coming years. We have included a description of the advisory panel and these guidelines as appendices to this paper.

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Acknowledgments: Support for development of this paper was provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services. Grateful appreciation is extended to the Ethics Workgroup of the Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT) for its invaluable assistance at every stage in the development of this paper. Particular thanks are extended to the following individuals for their review and comments on early drafts: Ben Bass, Tom Hill, Jesus Magallanese, Cheryle Pacapelli, Joe Powell, and Phil Valentine.

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APPENDICES

A. Ethical Decision-making Worksheet
B. PRO-ACT Peer Specialist Code of Ethics
C. "The Law and Peer-Based Recovery Support Services," Prepared by Renée Popovits and Elizabeth Donohue

ETHICAL DECISION-MAKING WORKSHEET

Step One: Who is vulnerable to harm in this situation, and what is the potential degree of such harm?

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

Step Two: What core recovery values apply to this situation, and what action would they suggest be taken?

✓	**Core Recovery Value**	**Suggested Course of Action**
	Gratitude & Service	
	Recovery	
	Use of Self	
	Capability	
	Honesty	
	Authenticity of Voice	
	Credibility	
	Fidelity	
	Humility	
	Loyalty	
	Hope	
	Dignity and Respect	
	Tolerance	
	Autonomy & Choice	
	Discretion	
	Protection	
	Advocacy	
	Stewardship	

Step Three: What laws, standards or historical practices might guide your conduct in this situation?

Step Four: Where risk of injury is great to multiple parties, document:

- What you considered:

- Who you consulted:

- What you decided and did:

- The outcome of the decisions you made and actions you took:

Preamble

PRO-ACT acknowledges its duty and obligation to those individuals, families, and communities it serves to assure the delivery of peer support according to recovery-focused guidelines, principles and values. Toward that end, we have: **1)** defined a code of conduct within a value-driven decision-making process that will guide delivery of our services and our service relationships; **2)** developed a Peer Specialist Review Panel; **3**) established ethical guidelines for the delivery of peer-based recovery support services provided through PRO-ACT; and **4)** outlined the process for recruiting and screening of potential peer specialists, training requirements both initial and ongoing, ongoing support, and supervision.

Value Oriented Decision-making Process

All PRO-ACT staff and volunteers shall follow the recovery guidelines and principles when making decisions involving complex choices, choices in which one or more parties could be injured by what we do or fail to do. They will develop the ability to recognize an ethical dilemma using the PRO-ACT decision-making questions to clarify their choices.

1.) Recognize when a situation arises that is a value-related issue.

2.) Use the PRO-ACT value-driven decision-making questions to clarify your choices.

3.) Seek consultation from supervisor and consider guidance from the Peer Specialist Panel to make the best possible decision.

4.) Communicate what you did, your rationale for what you did, and the outcome of the decision to your supervisor for purposes of review and documentation.

5.) Debrief the experience with others at PRO-ACT to enhance the sensitivities and ethical decision-making abilities of others.

Principle Decision-making Questions

All PRO-ACT staff and volunteers shall answer three questions as part of their process of ethical decision-making:

1) Who has the potential of being harmed in this situation and how great is the risk for harm?

2) Are there any core recovery values that apply to this situation and what course of action would these values suggest be taken?

*In this document the titles Recovery Mentor, Peer Specialist, and Recovery Coach are interchangeable. For brevity, the Peer Specialist terminology will be utilized.

3) What laws, organizational policies, or ethical standards apply to this situation, and what actions would they suggest or dictate?

Peer Specialist Panel

The Peer Specialist Panel consists of three to five individuals who volunteer their talents and time to assist PRO-ACT in analyzing and responding to complex value-related questions or dilemmas. This committee/panel will be made up of individuals in long-term recovery (with more than four years continuous recovery) who are widely known in the recovery community for their personal integrity, who can analyze and respond to complex principle dilemmas, and offer guidance in a timely and consistent manner when complex value issues arise.

Each panel member serves a yearly term that may be extended by mutual agreement between each panel member and PRO-ACT. The Panel must meet on a routine basis to set up their operational guidelines and to also be available in a timely fashion to respond to Peer Specialist complex principle or guideline dilemmas.

The Peer Specialist Review Panel will have input into the continuing education and training requirements of peer specialists based in part on the principle and guideline dilemmas that are presented to assure a continuous learning process is available for all parties.

All proceedings of the Peer Specialist Panel shall be recorded by the chair of the panel, and records of these meetings shall be kept for at least five years in confidential locked files.

Process for Recruiting, Screening, Training, and Supervision needs of Peer Specialists

PRO-ACT will use non discriminatory practices to recruit members of the Recovery Community representing a broad spectrum of recovery pathways. PRO-ACT will screen all applicants in order to assure the safety of all involved. All Peer Specialists and their supervisors are required to attend initial and ongoing trainings to enhance their job performance. PRO-ACT will develop trainings to enhance the various skills required, and will also focus on creating trainings to enhance Peer Specialists' cultural sensitivity and other issues of importance to the Recovery Community. PRO-ACT will provide opportunities to share and discuss complex principle or guideline dilemmas.

PRO-ACT Principles and Guidelines for Peer Specialists

As a Peer Specialist, I understand that my sole mission is to help individuals and families recover from addiction and its related problems. To that end, I will help remove or overcome all obstacles to recovery and help each individual and family find resources within and beyond themselves to both initiate and sustain the recovery process. My actions will be guided by the following core recovery values and service guidelines.

Gratitude & Service

I understand that my service to others is a sacred trust and that my actions flow from myself, from PRO-ACT, and from the larger recovery community. I offer my experience, strength, and hope to assist others in recovery out of gratitude to those who assisted me in my recovery.

Personal Recovery

I will work on my recovery so that I may be beneficial to those who depend on me for recovery support.

Face and Voice of Recovery

I will be a good example of recovery for those I serve.

Self-Improvement

I will foster self-improvement.

Honesty

I will tell the truth and when wrong, I will promptly admit it.

Authenticity

I will carry the recovery message in word and in deed.

Keeping Promises

I promise to keep my promises.

Humility

I will work within my limitations, handle disagreements respectfully, and seek help when I need it.

Loyalty

I will serve others as others served me and promote the recovery mission of PRO-ACT.

Hope

I will help others focus on their assets, strengths, and recovery possibilities.

Respect

I will honor the imperfections of others and myself and treat those seeking recovery with dignity.

Acceptance

I accept all pathways to recovery however diverse, even those opposite my own.

Recovery Integrity

I can carry the message, but I cannot carry the person. I help others by empowering the recovery of others.

Protection

I do no harm by respecting privacy and refraining from gossip. I avoid all forms of exploitation or harassment of those I serve. Our relationship is a sanctuary of safety.

Advocacy

I confront injustice when necessary on behalf of those who have not been empowered but never do for others what they can do for themselves.

Stewardship

I use or create resources in the wisest way possible to provide benefits others need to achieve recovery.

THE LAW AND PEER-BASED RECOVERY SUPPORT SERVICES

Prepared by Renée Popovits and Elizabeth Donohue

Overview

While the peer-based recovery support services trend within the addiction treatment community is not new, these services have rapidly expanded in recent years under various names, such as recovery coaches, recovery mentors, and peer specialists. Furthermore, these roles do not fit neatly within the "traditional" addiction treatment field, and little guidance can be found concerning the complex ethical and legal issues that arise when providing peer recovery support services.

Since this is uncharted territory, we have created this Addendum with the goal of providing a brief analysis of some common legal issues that addiction treatment providers address daily, and how these issues may or may not affect those providing peer recovery support services. Specifically, this article addresses the following issues:

- The application of 42 C.F.R. Part 2
- The application of the Health Insurance Portability and Accountability Act (HIPAA)
- Mandatory Child Abuse Reporting
- Informed Consent
- Organizational Liability

Federal Confidentiality Considerations

Confidentiality protections exist to encourage people to seek treatment for addiction to alcohol or other drugs or a mental illness. Mental health confidentiality is generally governed by state law as well as the federal HIPAA Privacy Standards. On the other hand, addiction treatment programs meeting certain criteria are governed by very stringent federal regulations (42 C.F.R. Part 2), which, in most cases, are far more protective of patient confidentiality than the HIPAA Privacy Standards.

Several providers furnishing recovery support services have questioned whether 42 C.F.R. Part 2 ("Part 2") applies to such services. To assist in determining the applicability of Part 2 to recovery support services, this article includes a decision-making diagram, contained in Exhibit A. The key questions a recovery support provider needs to consider are:

- Is the service a federally assisted "program" or part of a program within the meaning of Part 2?

- Is the service rendered by an employee or a volunteer of a "program"?

- Has a "program" contracted with a Recovery Support Specialist to render services as part of its continuing care?

- Is the person to whom you are providing recovery support services a "patient" within the meaning of Part 2?

- What are the services furnished by the Recovery Support Specialist, and are these services covered by Part 2?

- Do you receive or have access to "patient identifying information" protected by Part 2?

These questions are explored more fully below.

Are You a Federally Assisted Program?

The first legal consideration is the obligation to comply with the confidentiality restrictions imposed under federal law and regulations (42 U.S.C 290dd and 42 C.F.R. Part 2, respectively). The federal regulations prohibit "federally assisted substance abuse treatment programs" from communicating patient identifying information unless the regulations expressly authorize such disclosures for the purpose of treating substance use disorders, making a diagnosis for that treatment, or making a referral. A "federally assisted substance abuse program" is defined as an addiction treatment program that is:

1. Conducted in whole or in part by any department or agency of the United States;

2. Carried out under a license, certification, or registration or other authorization including certification under the Medicare program; authorization to conduct methadone maintenance treatment; or registration to dispense a substance under the Controlled Substances Act, to the extent that the controlled substance is used in the treatment of addiction;

3. Supported by funds provided by any department or agency of the United States, including receipt of Federal financial assistance in any form, including assistance from the State or a local government unit which in turn receives Federal funds that could be used for addiction treatment; or

4. An IRS tax-exempt entity.

Federally assisted programs, as used in Part 2, include programs funded by the federal government, as well as programs conducted under a license, certification, registration, or other authorization granted by any federal department or agency, including Medicare certification or authorization to conduct methadone maintenance treatment. Federal assistance also includes tax exemption granted by the IRS. Even if the program does not meet the definition of a federally assisted program, state law or state licensure regulations may require adherence to Part 2. This is because states can impose the same or more stringent requirements than Part 2. For instance, in Illinois, recovery homes have to comply with Part 2 via the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse licensure regulations. If this State licensure mandate did not exist, recovery homes would not be subject to Part 2 because they do not provide treatment services within the meaning of Part 2.

Are You An Employee of a Federally Assisted Program?

If the program meets the definition of a "federally assisted substance abuse program," then individuals who are providing peer recovery support services through the covered program must also decide whether they would be considered employees of the program for the purposes of Part 2, and would therefore need to comply with these regulations. Generally, if a Recovery Support Specialist is employed directly by a program and is receiving reimbursement by the program for the services he or she provides, the Recovery Support Specialist would be considered an employee. This applies even though the Recovery Support Specialist is not providing direct addiction treatment services to clients. If the Recovery Support Specialist is an employee, and has access to protected information through work (in whatever capacity) with the program, then the Specialist must comply with Part 2 (see 42 C.F.R. 2.12).

Do You Have a Contractual Relationship With a Program?

However, if the Specialist is not directly employed or affiliated with the program, but provides services to the program as part of a "continuum of care," most often through a contractual arrangement, then the Specialist would be considered a "Qualified Service Organization" (QSO) of the program. A QSO provides contractual services to the program that include access to information protected by Part 2. A QSO Agreement would be executed between the program and the Specialist and would contain provisions requiring the Specialist to protect the information received in the course of the work the Specialist is doing with the program.

Are You a Volunteer of a Program?

If the Recovery Support Specialist is providing services on a strictly volunteer basis, and is receiving no reimbursement for the services provided, then the Recovery Support Specialist must determine whether he or she would have access to protected information, and if he or she is providing services to a covered program. If the answer to these questions is yes, then the Recovery Support Specialist must comply with Part 2.

Is the Person You Are Providing Support To a Patient?

Part 2 strictly governs the disclosure of any information, whether recorded or not, that would either directly or indirectly identify a client as a person with an alcohol or other drug problem. Protection is afforded to each "patient" in a program, meaning any individual who has applied for or been given diagnosis or treatment for alcohol- or other drug-related problems at a federally assisted program. This includes any individual who, after arrest on a criminal charge, is identified as having an alcohol- or drug-related problem in order to determine that individual's eligibility to participate in a program.

Under Part 2, the confidentiality protections extend to "patients" in a program. Once an individual becomes a patient, all individually identifiable information about that patient is protected. Applicants for addiction treatment services are patients even if they are not admitted to the program. However, a person who does not show up for an appointment for an assessment to determine whether a substance-related problem exists is not a patient. Former patients and deceased patients remain protected as well.

Are You Providing Services To the Patient?

In some cases, Recovery Support Specialists will be employed by, or work with, Recovery Community Organizations (RCOs) that provide non-clinical recovery support services through paid and volunteer staff and act as "drop-in centers," service hubs, and places of fellowship. Remember, Part 2 applies only to programs and to those individuals who are employed by, or affiliated with, those programs. If the RCO does not meet the definition of a covered program, then Part 2 will not apply, unless there are more stringent State licensing or funding regulations. In addition, however, the RCO and/or the Recovery Support Specialists will need to make a determination whether the support they provide meets the definition of a "covered service" under Part 2. Some questions to be asked include:

1. Does the RCO provide "diagnosis" for clients? A diagnosis is defined as "any reference to an individual's alcohol or drug abuse, or a condition which is identified as having been caused by that abuse, which is made for the purpose of treatment or referral for treatment." However, this is not limited to assessments by medical professionals. An evaluation or assessment carried out by a counselor would be considered a "diagnosis" covered by the regulations. However, a "screen" or "prescreen" to identify individuals who may need to be referred to a specialist for a diagnosis would not be covered by Part 2.

2. Are targeted prevention services provided that are aimed at individuals who have been identified as having substance-related problems? If so, these services are covered by Part 2.

3. Is the referral of an individual to addiction treatment made after an assessment or diagnosis has been made? A referral for services alone is not enough to be covered by Part 2, but if the referral is made after a "diagnosis" has identified the person as suffering from a substance use disorder, then Part 2 applies. A referral for housing, medical care, or other similar services would not trigger Part 2.

For an in-depth discussion of each type of service rendered by a Recovery Support Specialist, consult the Legal Action Center's analysis in its newsletter *Of Substance*, entitled "Recovery Support Services – Are They Covered by the Confidentiality Regulations? Part I" (Vol. 26, No.3 May/Jun 2005).

Do You Have Access To Protected Information?

The drug and alcohol confidentiality regulations restrict both the disclosure and the use of information about individuals in federally assisted addiction treatment programs. 42 C.F.R. 2.3(a). Records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any program or activity relating to alcohol dependence or alcohol abuse, or in connection with the performance of any drug abuse prevention function, which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States, must be kept confidential. 42 C.F.R. 2.12(a) and (b).

Patient identifying information is defined broadly to include any information whereby the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information. The Privacy Standards also protect information that identifies or could reasonably be used to identify an individual. The Privacy

Standards contain many of the same "identifiers" as Part 2, as well as numerous additional identifiers which are afforded protection (i.e., client ID numbers). See the glossary for definitions of Protected Health Information (PHI) under HIPAA and patient identifying information under Part 2. It is also worthy to note that Part 2 covers any information (written or oral) relating to a patient that is received or acquired by a federally assisted addiction treatment program. The Privacy Standards cover PHI about an individual (oral, written, etc.) only when maintained, collected, used, or disseminated by or for a covered entity.

Records are broadly defined to include "verbal" (spoken) communications as well as what is typically thought of as written medical records. Therefore, patient records include any information relating to the patient, written or oral. In addition to disclosing any of the patient identifying information above, there are other ways of disclosing patient information (for example, giving written records with a patient's name on it or answering a telephone and informing the caller that the person to whom the caller wishes to speak is present).

the Health Insurance Portability and Accountability Act of 1996 (Hipaa)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to provide better access to health insurance and to toughen the law concerning health care fraud. In addition, it created national standards to facilitate the electronic exchange of health information and protect the privacy of any patient-identifying health information.

An addiction treatment "program" required to comply with Part 2 is not automatically a covered entity under the Privacy Standards of HIPAA. A covered entity is a health plan, health care clearinghouse, or health care provider who transmits any health information in electronic forms in connection with a covered transaction.

The Privacy Standards establish a federal floor of safeguards to protect the confidentiality of medical information by limiting the disclosure of PHI. PHI is any individually identifiable health information in **any** form: electronic, written, oral, or any other form. Protected health information may not be used or disclosed except as authorized by the patient or as permitted by the regulations. In other words, if the provider does not transmit any health information electronically, the provider is not a covered entity under the Privacy Standards. If the provider transmits health information in connection with covered transactions (see glossary) electronically via the Internet; an extranet; private networks; e-mail; or transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk, etc. then the privacy standards apply, even if all other information is kept in paper form.

Therefore, assuming the treatment agency is both a "Program" under Part 2 and a "covered entity" under the HIPAA Privacy Standards, PHI becomes protected upon its creation or receipt by the provider of treatment for substance use disorders (SUDs)[3]. The person does not have to be admitted as a patient. If a person calls and makes an inquiry and the addiction treatment abuse agency documents identifying information about the individual, the information would be considered PHI. This protection applies to any PHI in any form and remains protected for as long as the covered entity transmits or maintains it.

However, we should note that, based on the functions and services provided by RCOs, we believe it very unlikely that HIPAA would apply to RCOs, since RCOs would not be engaging in

[3] In cases where the 42 C.F.R Part 2 and the Privacy Standards apply and conflict, the more stringent of the two laws will apply.

electronic healthcare transactions. Therefore, the RCO would not meet the definition of a "covered entity" under HIPAA. In addition, based on a review of the functions and duties of Recovery Support Specialists, we have concluded that Recovery Support Specialists are not engaging in electronic healthcare transactions that would make them covered entities under the HIPAA.

How Do You Share Protected Information?

There are a number of ways to share protected health information without breaching a client's confidentiality. The most obvious is to use de-identified information or to disclose the information without identifying the person as a recipient of SUD treatment services. If you need to include patient identifying information, you may legally disclose: (1) with written patient authorization; (2) with a valid court order; (3) to staff within the program; (4) to a qualified service organization; (5) under a child abuse reporting exception; (6) to law enforcement for a crime on program premises or against program personnel; (7) to health care personnel for medical emergencies; (8) for research; and (9) for audit/evaluation activities.

Patient identifying information includes the name, address, social security number, fingerprints, voiceprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information (42 C.F.R. Section 2.11). In order to release this information, the regulations require the execution by the patient of a valid consent. Consents for disclosure are governed by the federal confidentiality regulations (42 C.F.R. Section 2.31) and must be in writing. To make a disclosure in accordance with these regulations, the following elements must be included in the written consent:

(1) Name of patient
(2) Name or general designation of program making the disclosure
(3) Kind of information and amount of information to be disclosed
(4) Name or title of person or organization to which disclosure is to be made
(5) Purpose for disclosure
(6) Date on which consent is signed
(7) Signature of patient
(8) Signature of parent or guardian, if applicable
(9) Statement that the consent is subject to revocation (except to the extent program has relied upon it)
(10) Statement that the consent will terminate upon a specific date, event, or condition

The federal confidentiality statutes and regulations, as discussed above, govern consent for disclosure. Prior to making a disclosure, a written consent form (containing the required elements of 42 C.F.R. 2.31) should be signed by the patient.

Mandatory Child Abuse Reporting

All fifty states have provisions for mandatory reporting of physical and/or sexual abuse of children. These statutes are based on the premise that the potential harm to children from abusive acts outweighs the potential harm that could occur through the violation of client confidentiality. The ethical command is to ensure that abuse does not recommence and to ensure the safety of other potential victims. The key question will be whether Recovery Support Specialists fall within a state's definition of a mandated reporter. If that is the case, there are three approaches the Recovery Support Specialist may follow.

The first approach takes the position that the Specialist should report only those cases of abuse that clearly fall under the definition of legally mandated reporting. This option makes compliance with the law the framework for ethical conduct. The risk here is twofold: first, that cases may arise in which there is an ethical mandate to protect which falls outside the legal requirement to report; and second, that actions taken to protect—mandatory reporting—may, in some unique circumstances, do harm to those targeted for protection.

The second approach takes the position that the Specialist should report only in those circumstances in which there is a legal obligation to report AND the action of reporting is judged by the Specialist to be the best available vehicle capable of protecting the innocent parties and supporting the long-term health and safety of all parties involved. With this option, a judgment not to report is an implicit assumption of responsibility and legal liability by the Specialist for the welfare of those involved, but one deemed justifiable under certain circumstances. In fact, in some states, a mandated reporter's failure to report child abuse or neglect is typically a misdemeanor, and grounds for disciplinary action by applicable licensing boards, if the Recovery Support Specialist possesses any such licenses. To further encourage reporting, some states also have immunity provisions for those who report abuse and neglect.

The third approach posits that the specialist should report, not only those cases that fall under the definition of legally mandated reporting, but also cases where the Specialist feels an ethical duty to protect but circumstances are not of such severity as to legally require reporting. The risk in this option is of unduly violating client confidentiality and of adding non-critical work to an already overburdened child protection system. Once again, if the specialist reports in "good faith," some state statutes provide immunity for such reporting.

For example, the Pennsylvania Consolidated Statutes, Title 23 (Domestic Relations), Chapter 63, states that any people who come into contact with children in the course of their employment, occupation, or practice of their profession shall report a reasonable suspicion of child abuse. Mandatory reporters include "social services workers," "child care workers," and "mental health professionals." In addition, child care services are defined to include "early intervention and drug and alcohol services for children."

Therefore, if the Recovery Support Specialist is also a mental health professional, the Recovery Support Specialist is a mandated reporter and must report child abuse under the statute. However, if (for example) a Recovery Support Specialist in Pennsylvania were not also engaged in a profession which is defined as that of a mandated reporter, there would not be a legal duty to report child abuse under the statute, but there might be an ethical duty to report governed by professional codes of conduct.

When in doubt, a Recovery Support Specialist should report child abuse. As stated above, most states have immunity provisions for those who report child abuse in good faith. In addition, the Recovery Support Specialist could face greater liability for not reporting. Furthermore, if the Recovery Support Specialist is not covered by Part 2, he or she will not be restricted by those regulations concerning the types of information he or she may disclose in connection with a suspicion of child abuse.

To reconcile the client's right to confidentiality with the duty to report, it is crucial that each agency clearly defines how it operationalizes both of these mandates within the span of the three positions noted above. Once that position has been determined, clients can be told of the

exceptions to confidentiality in language precise enough to allow them to make informed choices regarding likely responses to their disclosures.

There are numerous variations on abuse situations that make it more difficult to sort out one's legal and ethical duties. The agency/specialist response to each situation can be discussed using the following questions:

- Does the situation, as presented, warrant suspension of confidentiality and reporting to an outside authority? If yes, which outside authority?

- What actions in addition to, or as an alternative to, external reporting would enhance the protection of safety in the situation?

- Who will benefit, and who may be harmed by the proposed action?

- Which ethical values should guide our response to the situation?

Personal Or Organizational Liability

In general, courts have required that the patient be told: (1) the nature and purpose of the procedure; (2) the risks and consequences; (3) the alternatives; and (4) the risks of no treatment. Failure to disclose risk is the most common source of liability. This concept is known as informed consent. Because of the nature of Recovery Support Services, this concept of informed consent does not appear to apply. Nevertheless, people providing such services have questioned under what circumstances personal or organizational liability might accrue.

To determine whether a professional practice standard was breached, courts would look to the standards of what a reasonably prudent Recovery Support Specialist in the community would do in exercising reasonable care, as well as any statutory or regulatory requirements to determine the "appropriate standard of care." Liability in these cases is typically imposed on the individual as well as the agency under negligence theories. Thus, the plaintiff would be required to prove that the peer specialist had a duty and breached the duty, and that the client suffered injury as a result of the breach (meaning the peer specialist caused the client's injury) and damages were sustained. The key question in these cases is often whether the patient can prove that, had the risk been disclosed, he or she would not have consented to the procedure or treatment. In addition, liability could be imposed on the agency for failure to meet certain standards of care with respect to negligent hiring, training, supervision, or retention of staff. Some of the licensure, business, legal, and employment considerations that could impact these decisions and standards of care are:

- Will licensure regulations be modified to address this new role and the minimum standards for the state's seal of approval?

- Will funding agencies impose requirements on agencies employing this new role?

- Will these peer support roles be perceived as members of the "treatment team"? Are they volunteers? Are they interventionists? Are they case managers/outreach workers? Where do these roles fit in the continuum of care and supervision of the clinical team?

- Will reimbursement mechanisms for these new services drive the standards of care and associated breaches of those duties?

- Will certification agencies establish the standards of care and associated breaches of those duties?

- Will credentialing and other regulatory bodies establish the minimum credentials of those qualified to render services, thus imposing the corollary obligation to engage in appropriate recruitment, orientation, training, and supervision of the peer support specialists?

- What responsibilities will be imposed on Recovery Support Specialists to document their services?

- Will the existence of documentation change the role, expectations, and assumed liability of these peer support specialists?

- Will agency approaches to minimum sobriety "guidelines" impact the success of recruiting qualified peer support recovery specialists?

- Will agency codes of ethics relating to peer relationships with fellow clients affect "bright line prohibitions" of professional behaviors in the employment context?

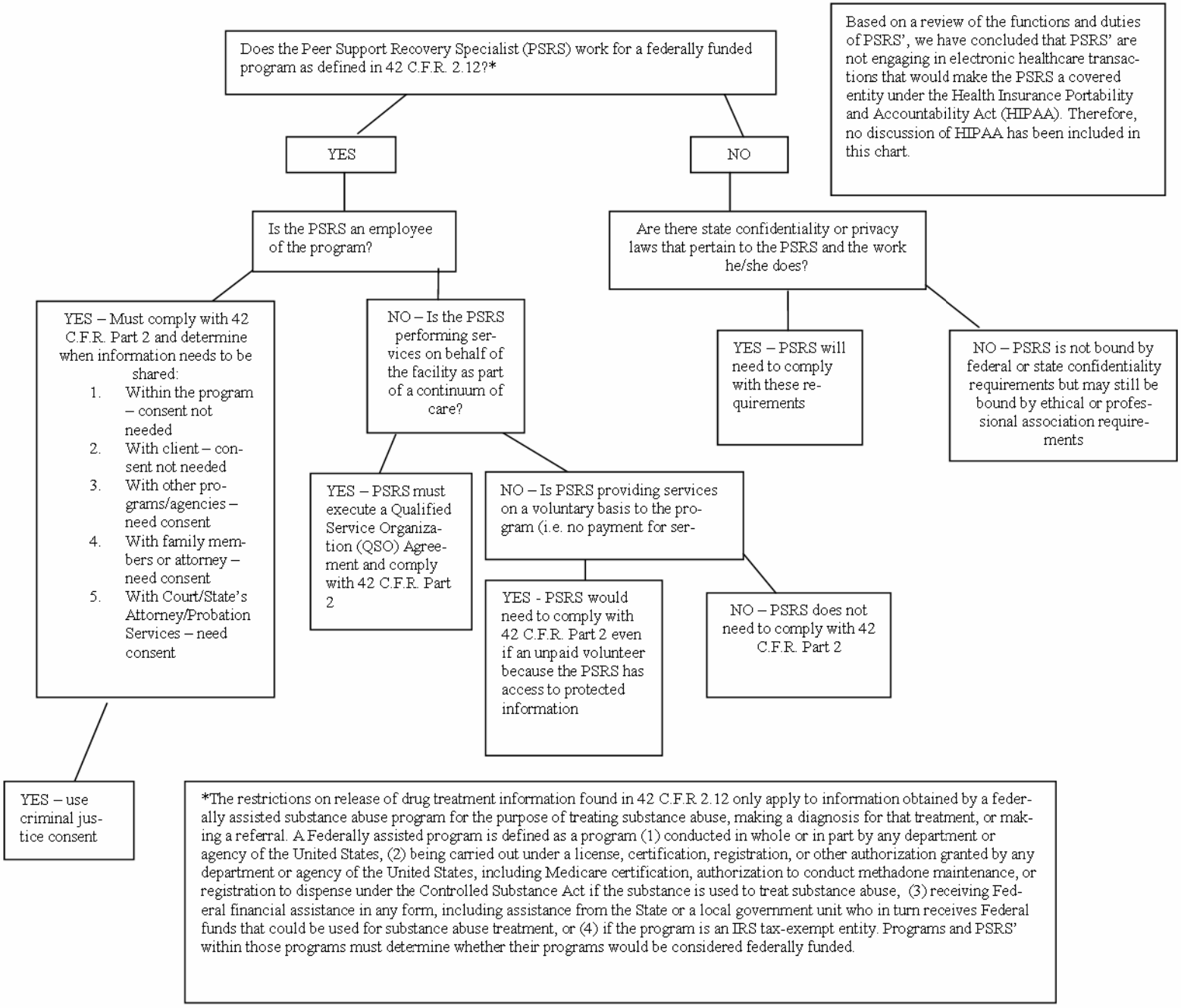
- What similarities exist between Recovery Support Specialists and consumer employees in the mental health field? What challenges have been encountered and lessons learned from that field that can be replicated for these positions?

- Will restrictions need to be imposed to "wall off" Recovery Support Specialists from information in a client record (including but not limited to joint clinical staffing to discuss client issues, the written medical record, the electronic information in clinical and billing systems), to preserve clients' right to confidentiality from fellow employee/fellow clients?

- With the Recovery Support Specialists presumably being involved with the clients for longer terms to support lifelong recovery, how does that impact the definitions of "clients" for purposes of determining whether a relationship can occur between a peer support recovery specialist and a "former client"?

At the present time, Recovery Support Services are deemed neither clinical nor medical procedures for which informed consent is required, and therefore there is a minor risk of liability. However, even as we speak, several states are modifying their licensure regulations to address Recovery Support Specialist services. Funding agencies will not be far behind. This public policy shift will have a huge impact on the nature of the services Recovery Support Specialists provide. As Recovery Support Specialists become an integral part of the treatment team and/or the continuum of care, we will witness licensing and funding authorities creating standards to govern these services, to justify reimbursement for them, and to create minimum levels of expectations. Once these standards are imposed, patients will have a greater ability to prove a breach of these standards and successfully sue Recovery Support Specialists for various types of liability.

Although standards professionalize the service, establish minimum public safety thresholds, and hold recipients of government funding accountable, mandated standards have contributed to survival strategies driving the addiction treatment field to focus on documentation, certifications, credentials, and reimbursement rather than the peer-based recovery concepts necessary for sustaining life-long recovery. This reality resulted in the peer-based recovery movement. Once federal, state, and local governmental authorities impose standards on these innovative recovery support services, they may very well destroy the effectiveness of the interventions that they choose to govern.


Does the Peer Support Recovery Specialist (PSRS) work for a federally funded program as defined in 42 C.F.R. 2.12?*
YES
NO
Based on a review of the functions and duties of PSRS', we have concluded that PSRS' are not engaging in electronic healthcare transactions that would make the PSRS a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). Therefore, no discussion of HIPAA has been included in this chart.
Is the PSRS an employee of the program?
Are there state confidentiality or privacy laws that pertain to the PSRS and the work he/she does?
YES – Must comply with 42 C.F.R. Part 2 and determine when information needs to be shared:
1. Within the program – consent not needed
2. With client – consent not needed
3. With other programs/agencies – need consent
4. With family members or attorney – need consent
5. With Court/State's Attorney/Probation Services – need consent
NO – Is the PSRS performing services on behalf of the facility as part of a continuum of care?
YES – PSRS will need to comply with these requirements
NO – PSRS is not bound by federal or state confidentiality requirements but may still be bound by ethical or professional association requirements
YES – PSRS must execute a Qualified Service Organization (QSO) Agreement and comply with 42 C.F.R. Part 2
NO – Is PSRS providing services on a voluntary basis to the program (i.e. no payment for ser-
YES - PSRS would need to comply with 42 C.F.R. Part 2 even if an unpaid volunteer because the PSRS has access to protected information
NO – PSRS does not need to comply with 42 C.F.R. Part 2
YES – use criminal justice consent
*The restrictions on release of drug treatment information found in 42 C.F.R 2.12 only apply to information obtained by a federally assisted substance abuse program for the purpose of treating substance abuse, making a diagnosis for that treatment, or making a referral. A Federally assisted program is defined as a program (1) conducted in whole or in part by any department or agency of the United States, (2) being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States, including Medicare certification, authorization to conduct methadone maintenance, or registration to dispense under the Controlled Substance Act if the substance is used to treat substance abuse, (3) receiving Federal financial assistance in any form, including assistance from the State or a local government unit who in turn receives Federal funds that could be used for substance abuse treatment, or (4) if the program is an IRS tax-exempt entity. Programs and PSRS' within those programs must determine whether their programs would be considered federally funded.



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Citation: White, W. (2007). How to enhance the odds for recovery. In Hoffman, J. & Froemke, S. Eds., Addiction: Why Can't they Just Stop? New Knowledge, New Treatment, New Hope (pp. 221). New York: Home Box Office.
http://www.hbo.com/addiction/aftercare/44_enhance_recovery_odds.html.
White, W. (2007). From treatment to sustained recovery.
http://www.hbo.com/addiction/aftercare/43_treatment_to_recovery.html.
Posted at **www.williamwhitepapers.com**

From Treatment to Sustained Recovery

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Professional treatment of alcohol and drug problems can start someone on the road to recovery, but a few weeks of treatment should not be mistaken for long-term recovery. If you have severe alcohol and other drug problems, you should know that successful recovery from these problems involves significant changes over time in personal identity and beliefs, family and social relationships, and daily lifestyle. It is about where you live, how you work and play, who is included and excluded from your life, and how you cope with the stresses of daily life. Recovery is more than just not drinking or using drugs; it is about putting together a new and meaningful life in which alcohol and drugs no longer have a place. Recovery from addiction is not like getting over an infection where we can rest and take medication for a week or two and then get back to our otherwise unchanged lives. Those who view treatment for addiction in this way make up the group for whom treatment does NOT work. Recovery from addiction is closer to how someone successfully manages diabetes or heart disease--conditions that require sustained decisions and actions for life. Here are some facts that reinforce this point.

What Happens After Addiction Treatment? Five Sobering Facts

1. Most people completing addiction treatment are fragilely balanced between sustained recovery and resumption of alcohol and drug use [1]: more than half will consume alcohol or other drugs in the year following discharge from treatment [2].
2. The window of greatest vulnerability for relapse after treatment is the first 30-90 days following discharge [3].
3. Between 25-35% of people who complete addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within 5 years [4].
4. Recovery is not fully stabilized (point at which future risk of future lifetime relapse drops below 15%) until four to five years of sustained recovery [5].

5. Sustained addiction can be lethal: relapses following addiction treatment produce high death rates from accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide and homicide [6].

The Good News

1. The positive effects of addiction treatment are substantial, as measured by sustained sobriety (about one-third of those treated) and decreases in substance use and substance-related problems [7].
2. Active participation in treatment aftercare meetings and recovery support groups such as Alcoholics Anonymous can significantly improve your chance of permanent recovery, improve your quality of life and prolong your life expectancy [8,9,10].
3. Combining professional treatment and attending recovery support meetings improve your chances of recovery better than either activity alone [11]
4. Lifetime recovery rates of people with a substance use disorder approach or exceed 50% [12, 13]. There are millions of individuals and their families in long-term recovery from the effects of severe substance use problems.
5. There are multiple pathways and styles (secular, spiritual, religious) of long-term addiction recovery [14]
6. Recovering people can go on to lead lives of significant achievement and community service [14].

6 Things You Can Do To Enhance Your Recovery Odds

1. Don't use—no matter what!
2. Choose a treatment program that offers a rich menu of continuing care services and actively utilize these supports [15].
3. Find a recovery support group [16] and stay actively involved (Make meetings a priority, get a sponsor, build a sober social network, and apply recovery program principles to problems of daily living).
4. If you do not have a living environment supportive of recovery, investigate the growing network of recovery homes [17].
5. Involve your family members in recovery support groups and activities [18].
6. Become an expert on your own recovery and take responsibility for it.

6 Things Families Can Do to Support Recovery of a Family Member

It has long been known that addiction can negatively affect all family members and disrupt family relationships [19], but recent studies have also shown that recovery from addiction can also exert great strain on family members and family relationships [18]. The person in recovery must construct a sober lifestyle at the same time family relationships have to be readjusted to the realities and demands of recovery. Here are several things family members can do to help speed these adjustments.

1. Educate yourself on the recovery process for individuals and families.
2. If your recovering family member is living with you, provide a sober environment to support that recovery.
3. Seek professional and peer support (from a group like Al-Anon) for your own physical and emotional health [19].
4. Support your family member's involvement in treatment aftercare meetings and recovery support groups.
5. Assist the recovering family member with assistance in locating sober housing, employment, child care, transportation or other recovery support needs.
6. Assertively re-intervene in the face of any relapse episode.

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recovery. Bill's sustained contributions to the field have been acknowledged by awards from the National Association of Addiction Treatment Providers, the National Council on Alcoholism and Drug Dependence, NAADAC: The Association of Addiction Professionals, the American Society of Addiction Medicine, and the Native American Wellbriety Movement. The Johnson Institute has just published Bill's widely read papers on recovery advocacy in a book entitled *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement.*



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Published with photos—Weiner, B. & White, W. (2007). The Journal of Inebriety (1876-1914): history, topical analysis and photographic images. *Addiction*, 102, 15-23. Posted at **www.williamwhitepapers.com**

Photo History Series
The Journal of Inebriety (1876-1914): History, Topical Analysis, and Photographic Images

Barbara Weiner and William L. White

Abstract

Aims The publication of the *Journal of Inebriety* (1876 to 1914) chronicled the rise and fall of the first era of organized addiction medicine in the United States. **Methods** Findings from historical research, a content analysis of the *Journal*'s 35 volumes and 141 issues, and images from the Journal visually illustrate the medical treatment of addiction in the United States in the late nineteenth and early twentieth centuries. **Results** Under the editorial direction of Dr. T.D. Crothers, the *Journal of Inebriety* published articles and reviews primarily focused on the medical treatment of alcohol and opiate addiction within a growing international network of inebriate homes and asylums. **Conclusions** The history of the *Journal of Inebriety* mirrors efforts in America to forge a legitimized field of addiction medicine amidst conflicting conceptualizations of the nature of severe alcohol and other drug problems.

Keywords: Journal of Inebriety, American Association for the Cure of Inebriety, addiction medicine, addiction publishing, history

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Introduction

Interest in the early history of addiction medicine in the United States is increasing [1, 2, 3], as is interest in the role of professional journals in the evolution and dissemination of addiction science [4, 5, 6, 7, 8]. This article reviews the history of the *Journal of Inebriety* (*JI*). The review includes a topical summary of all *JI* issues published between 1876 and 1914 and photographic images that illustrate the history of the *JI* and the professional field it represented.

The First Journal of Addiction Medicine

A dramatic rise in alcohol consumption in the United States between 1780 and 1830 and the subsequent increased consumption of opium and morphine spawned a medicalized concept of addiction, a therapeutic temperance

movement, and the spread of inebriate homes, inebriate asylums, and private addiction cure institutes across the American landscape [9, 1]. The first of these new specialty institutions that opened in the 1850s and 1860s varied considerably in their treatment philosophies and methods. Under the leadership of Dr. Joseph Parrish and Dr. Willard Parker, fourteen physicians, trustees, and lay leaders representing six inebriate homes and asylums met at the New York City YMCA on November 29, 1870 to found the American Association for the Cure of Inebriety (AACI). In 1888, the Association's name was changed to the American Association for the Study and Cure of Inebriety. The *Quarterly Journal of Inebriety* (*JI*) became the official communication organ of the AACI. The *Journal*'s name was changed in 1907 to the *Journal of Inebriety* (Volume 29).

The first issue of the *JI* was published in December 1876 at a subscription price of $3 per year, with single issues selling for $1 (Plate One). The last issue of the *JI* was published in March/April, 1914, at a price of $2 per year or $.50 for a single copy. Over the course of its history, 35 volumes and 141 issues of the *JI* were published, containing 801 major articles and 4,694 minor articles. A few newsletters emanating from particular treatment institutions preceded or were published concurrently with the *JI*, such as *The Washingtonian,* the newsletter of the Chicago Washingtonian Home, and *The Banner of Gold* and *Golden News,* newsletters of the Keeley Institutes. Two such publications—Dr. Robert Parrish's *The Probe* (Pennsylvania Sanitarium for Inebriates) (Plate Two), and Dr. H. H. Kane's *Journal of Stimulants and Narcotics* (De Quincey Home)—aspired to compete with the *JI* as the leading addiction medicine journal, but the *JI* survived as the primary publication focused on addiction treatment throughout the years it was published [7].

The success of the *JI* can be attributed in great measure to the editorial leadership of Dr. Thomas Davidson Crothers (Plate Three). Crothers, who served as the editor of the *JI* through its entire history, was a leading figure in nineteenth century addiction medicine. Born in 1842 in West Charlton, NY, he graduated from Albany medical school in 1865 and worked in private medical practice before accepting the position of assistant physician at the New York State Inebriate Asylum in 1875. The New York Inebriate Asylum had the distinction of being the world's first medically-oriented addiction treatment institution. Crothers was appointed secretary of the AACI and Editor of the *JI* in 1876 and held these positions throughout the AACI's history. In 1878, he assumed the position of superintendent of Walnut Hill Asylum (renamed Walnut Lodge Hospital in 1880) in Hartford, CT (Plate Four) and used that position as a platform to advocate the medical treatment of addiction until his death in 1918 [10, 11].

The *JI*'s first (December, 1876) issue of 5,000 copies was printed and distributed from Hartford, Connecticut. The *JI*'s central proposition that inebriety was a disease was immediately greeted by what AACI leaders later characterized as "violent opposition", "adverse criticisms and bitter condemnation", and "hysterical denunciations". Most of these reactions were from religious leaders who viewed the journal as excusing crime and dignifying vice [12, 13, 14, 15]. Adding to animosity toward the journal was Crothers' rejection of papers submitted for publication in the *JI* by clergy and temperance advocates on the grounds that the papers lacked scientific merit. To the chagrin of those on both sides of the temperance question, Crothers was adamant: The *JI* was about science, not temperance dogma [13]. Similar reactions were elicited from papers submitted by the heads of treatment institutions that were in Crothers' view nothing more than "concealed advertisements" [15, p. 145].

The rising strength of the American Temperance Movement fueled debate over the use of alcohol in medicine and led to the founding in 1891 of the American Medical Temperance Association (AMTA), an association organized by Dr. Nathan Davis that advocated the legal prohibition of alcohol and a ban on the use of alcohol in medicine. AMTA published a competing

journal, the *Bulletin of the American Temperance Association*. Crothers provided the connecting link between the AACI and this new association, serving as secretary of both groups.

As AACI membership peaked at 500 members [16], Crothers predicted a future "radiant with promises of greater progress" in the acceptance of the medical treatment of inebriety [14, pp 93-94], but forces were coalescing to threaten that vision. In the first two decades of the twentieth century, America's response to alcohol problems shifted from a focus on the vulnerability of the individual (alcoholism) to the universal perniciousness of the product (alcohol)—a shift reflected in the final drive for national prohibition of alcohol. The founding of the Scientific Temperance Federation in 1906 and its publication of the *Scientific Temperance Journal* (Plate Five) to compete with the AACI and the *JI* reflected that shift [7].

In 1904, the AACI and AMTA merged under the name, the American Medical Society for the Study of Alcohol and Other Narcotics (AMSSAON). Three years later, the *Journal of Inebriety* and the *Archives of Physiological Therapy* merged under the former's title [16]. The AACI struggled to sustain itself as the field it represented collapsed in the policy shift toward the legal prohibition of alcohol and the legal regulation of opiates and cocaine. Cultural pessimism about addiction treatment and the prospects for long-term addiction recovery grew amidst glowing optimism about the prospects of prohibition. In that cultural environment, treatment institutions seemed to be an anachronism [17].

In 1907, publication of the *JI* was transferred to the Gorham Press in Boston and was transferred again in 1913 to the Therapeutic Publishing Company of Boston, at which time it was announced that the *JI* would move from quarterly to bi-monthly issues. The March/April 1914 issue of the *JI* announced that the *Journal of Inebriety* "passes into the hands" of The Journal of Inebriety Publishing Company headed by T. D. Crothers, but no other issue of the *Journal of Inebriety* was ever published. AMSSAON collapsed sometime in the 1920s, and only a handful of nineteenth century treatment institutions survived the 1920s. A small number of private addiction treatment institutions rose amidst the collapse of the old, but several decades passed before Americans witnessed a renewed field of addiction medicine and new specialty journals that carried forward the legacy of the *Journal of Inebriety*.

International Connections

Over the course of its existence, the AACI's *JI* was quite international in its orientation. AACI leaders were very cognizant of the birth of inebriate asylums in Europe and the founding of counterparts to the AACI in England, France, Germany, Switzerland, Belgium, and Italy. Leaders of the association regularly participated in meetings of the International Congress of Inebriety; the *JI* published articles written by authors outside the United States, and *JI* articles were frequently translated into German, French, and Italian [13]. The *JI* reported on trends, laws, and treatment methods in other countries. Our analysis of major and minor articles published in the *JI* between 1876 and 1914 reveals a total of 427 articles originating from or focusing on events outside the United States, with most of these articles coming from England (153), France (64), Germany (37), Canada (17), Austria (12), China (10), Prussia (10), Russia (9), and Scotland (9). Of the 801 major articles published over the course of the *JI*'s history, 101 were authored by individuals outside the United States with the majority of these coming from England (48), France (11), Canada (8), Scotland (7), Belgium (5), Germany (5), and Austria (4). The English inebriety pioneer Dr. Norman Kerr (Plate Six) exerted a particularly important influence on Crothers and the American inebriety treatment movement. There was no direct counterpart in the nineteenth century to today's International Society of Addiction Journal Editors, but there was considerable international contact between the inebriety leaders in America and Europe.

Authorship Analysis

Over the course of its history, the *JI* published articles authored by 230 individuals. Nine individuals published ten or more articles in the *JI*: Drs. T. D. Crothers (71), Lewis Mason (26), Norman Kerr (22), T. L. Wright (21), N. S. Davis (12), Winfield S. Hall (12), Albert Day (11), Edward Mann (11), and Joseph Parrish (11). Physicians authored more than 90% of the articles published in the *JI*. Professors, lawyers, and members of the clergy were most visible among those authors who were not physicians. Of American authors who published major articles in the *JI*, most were drawn from the Northeast (particularly New York, Massachusetts, and Pennsylvania) and the Midwest (particularly Illinois and Ohio). Women authored only seven major articles in the history of the *JI*. Drs. Louise Robinovitch (Paris, France), Lucy Hall (Sherburne, Massachusetts), and Agnes Sparks (Brooklyn, New York) penned articles that called attention to the special needs of addicted women. In light of the fact that single authorship of scientific articles in the addictions field has become rare [18], it is interesting to note that only three major articles and one review were co-authored in the entire history of the *JI*.

Content Analysis

The early format for the *JI* remained constant through most of its history. Each issue consisted of major papers, proceedings of the AACI (papers and reports appearing in the issue following each meeting), abstracts and reviews, editorials, clinical notes and comments, and advertising. Evaluation of the topical content of the *JI* first required assembling originals or photocopies of all volumes and issues of the *JI* from various addiction studies archives and libraries. It took four years of searching to fill in missing issues and pages from such resources as the National Library of Medicine, Connecticut State Library, Center for Research Libraries, UMass Medical Center Library, College of Physicians of Philadelphia, and the New York Academy of Medicine. In a world where so much information is digitized and electronically stored, easily accessible, and fully searchable, it is noteworthy that the social, scientific, and historical information in the *JI* is not indexed in any electronic database. Once all issues of the *JI* had been collected, a content analysis was conducted using the following steps.

1) A topical list was independently prepared by each author based on sample issues from three different decades of the *JI*.
2) The topical categories and subcategories were merged into a single list and then sample issues were reviewed together to identify missing topics and to establish norms for topical placement.
3) The lead author conducted the topical analysis of all articles appearing in the *JI* using the revised list and the established placement norms.
4) Placement was based on the article title and, where necessary, a review of the article content.
5) When completed, the number of entries within each category and subcategory were tabulated and charted.

Highlights of that topical analysis are presented below.

Major Topics: Between 1876 and 1914, there were 14 broad topical areas that generated 25 or more main articles in the *JI* (Table 1). Occasional *JI* topics sound tantalizingly familiar to contemporary issues: teachers not allowed to smoke on school grounds during school hours (1902); reports on the need for institutional aftercare (1902); and calls to teach about alcohol and addiction in medical school curricula (1907).

Patterns of Use/Addiction: The *JI* was quite eclectic in its interest in intoxicants, noting more than 38 intoxicating agents in its major and minor articles. Alcohol, opiates, and tobacco dominated the subject matter of the *JI*, accounting for 88% of the major and minor articles that focused on a particular intoxicating agent. The rank ordering of

these substances was alcohol (57%), opiates (21%), tobacco (9%), coca and cocaine (5%), caffeine (coffee and tea) (4%), and, each with less than 1%: tonic stimulants (e.g., arsenic and strychnine), chloral, hashish (cannabis), and chloroform. Although intoxicants other than alcohol find press throughout all the years of the *JI*'s existence, only years 1908-1914 have this subtitle printed on its title page: "First and only journal devoted to spirit and drug neurosis".

Concern with Health Complications: A total of 750 major and minor articles in the *JI* addressed medical complications associated with inebriety. Of all articles dealing with medical complications, 174 provided a broad discussion of the physical complications of inebriety while the remaining articles focused on particular ailments. Those complications that drew 20 or more specific articles focused on the brain and nervous system (other than epilepsy) (74), the respiratory system (particularly concerns related to tuberculosis) (46), delirium tremens (42), visual impairment and blindness (41), heart (27), epilepsy (27), digestive system (23), and sexual dysfunction (20).

Medications: The *JI*'s preoccupation with medications marked both the ongoing search for medicinal specifics that could cure addiction and the search for medicinal solutions to particular treatment dilemmas, e.g., the management of withdrawal, the suppression of craving, and the treatment of collateral medical problems. The *JI* exposed the ineffectiveness of a wide variety of alleged cures, including sodium calcium, wine of antimony, snake root, cinchoma, and the secret ingredients of the various "gold cures". Of the 625 articles that specifically focused on drug-based treatments, 101 articles provided a broad discussion of medicinal treatments while the remaining focused on the effectiveness or ineffectiveness of particular substances: phosphates (100), opiates (39), anti-ethylic serum (30), bromides (29), Celerina (21), coca/cocaine (15), Bovinine (14), Beef Tonic (13), and strychnine (12).

Other Treatment Techniques: A total of 185 articles in the *JI* addressed non-pharmacological techniques used in the treatment of inebriety. Those methods garnering focused articles included hypnotism (suggestion) (40), hydrotherapy (34), electrical stimulation (33), hygiene (20), muscle vibration (13), light therapy (8), psychotherapy (5), and hot air baths (5).

Treatment of Women: Over the span of its existence, 54 articles appeared in the *JI* on the special needs of and treatment approaches for female inebriates. This special focus reflected the growth of specialized treatment institutions in the United States for the treatment of addicted women between 1860 and 1900.

Core Ideas and Language

When the AACI first met on November 29, 1870, its founders established a set of founding principles that guided the AACI and formed the ideological foundation of the *JI* throughout its existence. These propositions declared that *1) Intemperance is a disease. 2) It is curable in the same sense that other diseases are. 3) Its primary cause is a constitutional susceptibility to the alcoholic impression. 4) This constitutional tendency may be either inherited or acquired* [12, p. 192]. The founding principles further posited that all past remedies for intemperance (e.g., fines and jail) had failed and called for the establishment of temporary homes for inebriates in every large city and the establishment of inebriate asylums in every state. Although the disease nature of inebriety was debated early in the history of the AACI, the association and its *JI* maintained fidelity to these propositions throughout their existence.

The *JI* also reflects the early competition for terms to characterize excessive alcohol and drug use, terms such as habitual drunkenness, inebriety, ebriosity, dipsomania, narcomania, oinomania, alcoholism, and addiction [19]. In an attempt to identify the rising popularity of the latter two terms, we tracked their appearance in the titles of articles appearing in the *JI*. The term *alcoholism* first appeared in *JI* titles in

1877-1878, peaked in 1903 (with a total of 18 appearances in the titles of major and minor articles), and declined in frequency of appearance between 1903 and 1914. The term did not gain cultural or professional prominence in America until the mid-twentieth century. The term *addiction* in the *JI* referred primarily to dependence upon drugs other than alcohol. It first appeared in 1890 in reference to chocolate, but appeared less frequently in titles than did the term *alcoholism*. *Inebriety* continued as the professional term of choice throughout the *JI*'s history to communicate dependence on a broad spectrum of psychoactive drugs.

Advertising Analysis

The *JI* did not represent all treatment institutions nor would it allow all such institutions to advertise in its pages. Crothers used the pulpit of his *JI* editorial role and books to attack the private addiction cure institutes that promised medicinal specifics as a cure for inebriety and pushed through a *JI* advertising policy that specifically banned advertisements by the "Gold Cure Institutes" [15]. Two types of institutions did advertise extensively in the *JI*. The first claimed to offer specialized treatment for inebriety and constituted a mix of inebriate homes and asylums (Plates Seven & Eight), while the second might be aptly described as sanatoria or convalescent centers (Plates Nine & Ten). Between 1876 and 1914, advertisements appeared for a total of 78 different institutions that offered specialty treatment for addiction or convalescent care. Twenty of these institutions advertised in five or fewer issues of the *Journal of Inebriety*, while advertisements for the following institutions appeared 40 or more times over the history of the *JI*: Inebriate's Home (New York City), the Washingtonian Home (Boston, MA), Walnut Lodge Hospital (Hartford, CT), Brooklyn Heights Sanitarium (Brooklyn, NY), the Homewood Retreat (Guelph, Ontario), and the Highlands (Minchendon, MA).

In addition to advertisements for treatment institutions, the *JI* carried advertisements for medical schools, addiction texts and journals, medicines, mechanical devices (for massage, electrical stimulation) (Plates Eleven & Twelve), and non-medical products and services (e.g, photography).

Conclusions

The *Journal of Inebriety* served as the primary instrument of communication between those involved in the treatment of addiction in the late nineteenth and early twentieth centuries. The rise and fall of the *JI* mirrors the fate of the larger professional arena that it served and its pages tell us much about the early history of addiction and its treatment in America. Twenty-first century readers of the *JI* will be struck by such oddities as the recommendation for bee stings or syphilis as treatments for inebriety, but readers of the *JI* will also be amazed at the parallels to contemporary interests and debates within the addiction field. We would encourage those writing scientific articles today to use the *JI* as an invaluable resource for setting contemporary issues in historical context.

Acknowledgment: Thanks are extended to Penny Page (Librarian, Rutgers) and Rebecca Rowe (Library Assistant, Hazelden) for their assistance.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2007). Listening to Meth: Lessons from the first epidemic. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*. Posted at **www.williamwhitepapers.com**

The Voice of History
Listening to Meth:
Lessons from an Earlier Epidemic

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America has a short memory. In the current alarm about the spread of methamphetamine dependence, one rarely hears of the methamphetamine epidemic of 1968-1972. The lessons from that earlier era indicate five potential strategies for recovery advocates.

Anticipate the Cycle. The first methamphetamine epidemic didn't disappear; it morphed into alcoholism, sedativism and narcotic addiction. Community responses to methamphetamine must anticipate problems that will emerge in the wake of this latest epidemic. Methamphetamine is a problem in its own right, but it is also a Trojan horse through which opiate addiction can enter unsuspecting communities.

Calm the Response. The first media and professional reports on any new drug trend are notoriously unreliable. Exaggerations and outright fabrications must be replaced with science-grounded facts. Hysteria must be replaced with well-conceived strategies. Wars on new drugs must be prevented from morphing into new wars on the disaffiliated. We must also avoid fanning these flames for our own personal and institutional interests. We must help communities avoid doing great harm in the name of good. Ours must be the voice of reason and compassion.

Ride the Cycle. In spite of the "Speed Kills" mantra of the first epidemic, the consequences of methamphetamine dependence were measured more in long addiction careers than in overdose deaths. We need to interrupt these careers as early as possible through assertive outreach programs, visible and effective treatment and sustained recovery support services. The doorways of entry into this epidemic must be narrowed as the doorways of exit are widened.

Create Recovery Space. Most addicts suffer from terminal uniqueness, and each new generation of addicts sees itself as different from those who came before. Physical and psychological space within the

recovery community must be created for each new generation and the drug-specific experiences it brings. The welcoming invitation into the culture of recovery must be warmer than the siren call of methamphetamine and the social world in which it is imbedded.

Offer Hope. There is a tendency in this culture to portray any new drug trend as more pernicious than anything that preceded it. The past and current methamphetamine epidemics offer vivid testimony of the destructive effects of methamphetamine on individuals, families and communities.

But the story of meth addiction is incomplete without the evidence of long-term recovery. Every story on methamphetamine should contain a recovery message. It is our job as recovery advocates to offer the living proof of that message. We must find and elevate the faces and voices of methamphetamine recovery from past and present epidemics.



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Citation: Iliff, B, Siatkowski, C., Waite-O'Brien, N. & White, W. (2007) The treatment of addicted women: Modern perspectives from the Betty Ford Center, Caron Treatment Centers and Hazelden. *Counselor*, 8(3), 42-48. Posted at **www.williamwhitepapers.com**

The Treatment of Addicted Women: Modern Perspectives from the Betty Ford Center, Caron Treatment Centers and Hazelden

Brenda J. Iliff, MA, Candis Siatkowski, BS, Nancy Waite-O'Brien, PhD and William White, MA

The history of specialized addiction treatment for women in the United States has a long history dating to such nineteenth century institutions as the Martha Washington Home in Chicago (1869), the Temple Home in Binghampton, N.Y (1876), and the New England Home for Intemperate Women in Boston (1879) (White, 1996). Previous articles in this column have chronicled the history of addiction among American women (White & Kilbourne, 2006), summarized the early history of gender-specific treatment (White, 2002), and honored some of the pioneers in gender-specific treatment (White, 2004). This article profiles the treatment of addicted women at three prominent private institutions: Betty Ford Center, Caron Treatment Centers, and Hazelden. The article closes with a discussion of what these institutions have learned about the treatment of addicted women.

Hazelden

A synergy between three alcoholism treatment programs—Pioneer House, Hazelden and Willmar State Hospital—created a new approach to treatment in the mid-twentieth century that became known as the "Minnesota Model." Hazelden opened its doors for the treatment of "curable alcoholics of the professional class" in 1948. When the need for special services for women became apparent in 1956, the Hazelden board, under the leadership of Patrick Butler, responded to this need by opening Dia Linn, a special facility for women located near White Bear Lake, Minnesota. This action occurred at a time few if any treatment programs for addicted women existed in America. Hazelden's Dia Linn expanded its capacity at the White Bear Lake facility in 1962 and then moved to the main Hazelden Campus in Center City, Minnesota in 1966.

Dia Linn offered a significant resource for alcoholic women in the 1950s and 1960s as addiction among women was highly stigmatized in these years, and there were few treatment options other than the wards of state psychiatric hospitals. Several people contributed to the design of Hazelden's early services for women, including Dorothy Borden, Phoebe Brown, Hazel Taylor, and Jane Mill. The program itself was a simple one, with daily life filled with housekeeping

chores, lectures, conversations, and AA meetings (McElrath, 1987). Such simplicity obscured the fact that women were on a separate campus because of fears of what effects their presence would have on the men treated at the main campus. During that time, being a woman and alcoholic was associated with being a "loose woman". There was considerable fear of bringing the women to what was originally an all-male campus. Fortunately, these fears were totally unfounded in practice.

During the 1960s, Dia Linn revamped its program under the guidance of clinical psychologist John Harkness. Each woman was assigned a primary counselor, group therapy, a more formal lecture schedule was added to the daily schedule, 24 hour nursing coverage was added, and clergy and social workers. This evolved into the multidisciplinary team that became a core part of the "Minnesota Model" and then spread to many treatment centers. Friday aftercare sessions were also added for alumni, and a formal family program was developed (McElrath, 1987). In the 1970s, Hazelden launched Women for Women, a volunteer program that identified and referred women to treatment, developed specialized aftercare groups for women, and designated 16 halfway house beds at Fellowship Club for women. This was followed in the 1980s with the development of a specialized 14-week women's outpatient program in Minneapolis as well as specialty programs offered for women at Hazelden's Renewal Center, a retreat environment for people in recovery.

During the 80s, Hazelden started offering specific mental health services for women in chemical dependency treatment, including services related to trauma and eating disorders. While the primary focus was on chemical dependency, Hazelden became aware that these and other issues could be major blocks in recovery and needed to be addressed. Throughout the 80s and 90s, integration of the multidisciplinary team around women's mental health needs assisted more women into recovery.

Hazelden's specialized services to women continued to grow with the opening of the Women and Children Recovery Community in New Brighton, Minnesota in 1997. This marked Hazelden's movement into the development of sober housing for newly recovering women and their children (McElrath, 1999). Hazelden's commitment to women's services culminated in 2006 with the opening of the Women's Recovery Center. The center is located on the main Hazelden campus and consists of two 22-bed primary treatment units. Since the first woman was admitted to Dia Linn in July 1956, Hazelden has helped more than 40,000 women through their various programs and service sites.

Today, women treated at Hazelden are afforded many gender-specific services, including a daily women-only topical lecture series, special education on trauma and eating disorders and parenting in recovery, creative services time for mother and children to do a project together during visiting hours, and specialized women's health services—all grounded within Hazelden's historical emphasis on the Twelve Step philosophy. Also available to these women are the more than 50 products developed exclusively for women in recovery by Hazelden Publishing and Education.

The Caron Treatment Centers

In 1957, Richard and Catherine Caron created a vision of helping alcoholics find sobriety by creating an alcoholism treatment center in Pennsylvania. The vision came to reality in the founding of Chit Chat Farms, which evolved into the Caron Foundation and today Caron Treatment Centers, one of the most prominent addiction treatment organizations in the country. This year, Caron celebrates 50 years of providing comprehensive addiction treatments.

In the early days, before treatment services were formally developed, the Carons opened their home in Wyomissing Hills, Pennsylvania, to men and women seeking recovery from alcoholism. As this

dream developed, the Carons had to find additional facilities to house the men and women who continued to show up at their doorstep. A home was purchased in Reading, PA which served as a half-way house for men while, women continued to stay at the Caron home until 1961. Many of these women were from the State Correctional Institution for Women at Muncie, Pennsylvania, and were on parole doing a work-release program. In that year, Chit Chat Farms joined a small number of organizations in the country offering inpatient addiction treatment for women. On April 1, 1961, Chit Chat admitted its first female patient, and by the close of 1961, 13 of Chit Chat's 192 residents were women (Holton, 1997).

Early treatment of women at Chit Chat included individual and group counseling sessions, meetings with a physician and psychiatrist as needed, mandatory AA meetings in Reading, Pennsylvania, on Monday and Saturday nights, and occupational therapy for each woman. The latter earned each woman $1 per hour, which was deducted from her bill. In 1968, the first new facility built specifically for women was opened, and the number of women treated at Caron continued to expand throughout the 1970s and into today. Formal 12-step work was integrated into the treatment programs, but there were no gender specific groups and little family work during these early years.

An important person who had a profound effect on Caron's services to women was Miss Rosie Kearney, a self-described "bag lady" living on the streets of Brooklyn, who found sobriety at Chit Chat Farms and dedicated her life to helping other women achieve recovery. Rosie used to joke that she "came for 28 days and stayed for 24 years." Rosie organized alumni dinner dances and used the funds she raised to purchase a home for recovering women in Mohnton.

The Rosie Kearney House (RKH), in Mohnton, PA housing 18 women, began as a halfway house and over the years expanded into an extended care facility. It opened in 1983 and was relocated in 2004 to Caron's main campus in PA. In the beginning, RKH was designed to assist women who were misplaced/homeless after treatment. The patients received AA-based therapy, shared in housekeeping duties, and sought employment.

Treatment services at Caron from the 1960s through the mid-1990s were co-ed, with few specialized services for women. In 1996, under the direction of Caron's new CEO, Douglas Tieman, the Board of Directors at Caron approved gender-separate and gender-specific treatment as part of Caron's strategic plan. Treatment of women from that point forward has been distinguished by its emphasis on empowerment, safety, reducing feelings of stigma and shame, learning tools for effective decision-making strategies, balancing self-care and care-taking, establishing and maintaining boundaries, identifying and changing negative relationship patterns, and providing a healthy, healing relationship between the therapist and the patient.

Today, women who are admitted to Caron receive additional specialized services for such problems as eating disorders, codependency, trauma, and self-injurious behavior. They work on issues such as parenting, work problems, establishing balance between self-care and other responsibilities, and are encouraged to seek employment or do volunteer work. The Rosie Kearney House is now a Women's Extended Care Unit and provides up to an additional 90 days of treatment by focusing on identification of triggers and the development of interventions for these triggers. Some of the focuses during extended care are to develop intimacy with other women, develop a spiritual practice, build a recovery network, find a 12-step sponsor, and attend meetings for transitioning back into society. In 2000, after conducting extensive research on its women patient population, Caron published a special research report entitled, *Women and Addiction*, focused on the critical and unique treatment needs of women. (Gordon, 2000).

The Betty Ford Center

The Betty Ford Center opened on October 4, 1982, to fulfill the vision of Mrs. Ford and Center Director John Schwarzlose to create a treatment program based on the 12 Steps of Alcoholics Anonymous that was also sensitive to the needs of women. President Ford and Leonard Firestone encouraged Mrs. Ford to allow the Center to be named in her honor because of the effect this would have on women seeking services. Dr. Dan Anderson, then President of Hazelden, encouraged Mrs. Ford to focus the new center on the treatment of addicted women.

Four residence halls were built at the Betty Ford Center between 1982 and 1986, with the fourth designated by the donors as a treatment unit for women. The question of whether to treat all clients in gender-specific units was frequently debated by Mrs. Ford and the Board of Directors. In 1988, the question of whether to offer gender specific treatment was posed to the staff of 14 counselors. The outcome was seven in favor of separate sex treatment and seven in favor of co-ed treatment. Mrs. Ford cast the deciding vote: the Center would work toward providing separate treatment units for men and women. Fully implementing this decision took considerable time.

In the early 90's, the Betty Ford Center contracted with an external organization to conduct follow-up research with patients who had completed treatment, with particular attention to abstinence rates of the women who were treated in the co-ed unit versus the women treated in the single sex unit. The data from their 1992-1993 follow-up calls revealed that the women who were treated in the single sex unit were significantly more likely to be sober at the end of a year than those who were treated in the co-ed unit. These results were amplified by the fact that women who were predicted to have a better prognosis for recovery (i.e. stable home life, older, established career) tended to be assigned to the co-ed unit while those who were thought to have a worse prognosis for recovery based on being younger, single, and having histories of multiple drug use were assigned to the single sex hall. Surprisingly, the "high risk" women treated separately had better recovery outcomes than those women treated in the co-ed unit. This prompted the Board and administration to fully shift to single-sex treatment units in late 1993. As a part of this shift, staffing in the women's halls became exclusively female.

The structure of women's treatment at the Betty Ford Center was influenced by several key people: Mrs. Ford, Susan Ford Bales, Center staff members Ann Vance, Geneva Burns, Monessa Overby, and Dr. Nancy Waite-O'Brien. When women were moved into separate units that were staffed completely by women, the content of therapy, particularly group therapy, shifted almost immediately (as it also did in the men's units). Areas of vulnerability and hurt such as childhood sexual and physical abuse as well as violence in current relationships that had not been talked about in mixed-sex groups quickly emerged as significant topics of discussion. Women who had shaped their self-images and their addictions in the shadow of the men began to learn how to assert themselves in the units and in all-women AA groups. Over time, specialty groups were added that focused on such issues as trauma and eating disorders, special educational groups were added, and the center's bookstore stocked books and pamphlets supporting women's recovery.

In 2000, a longer term Residential Day Treatment program was started that allowed patients to live in homes purchased by the Center and to participate in formal treatment five days a week. This program allows women to be a part of the local recovery community, to live with other recovering women, and to practice their recovery skills in the community.

Between 1982 and 2006, the Betty Ford Center has treated more than 75,000 individuals and family members, with women making up 44% of primary care patients. The women's program continues to evolve

as staff and former patients reflect on their collective experience.

The Betty Ford Center, Caron Treatment Centers, and Hazelden have all, collaboratively and independently, hosted major professional conferences on addiction, recovery, and women since 1996.

Shared Lessons

The distinguished institutions profiled in this article have been pioneers in the development of gender-specific treatment services. The lessons about the treatment of addicted women drawn from the cumulative experience of these three institutions are reflected in the following 14 propositions.

Patterns: Our clinical experience confirms the major finding of modern gender research: everything we have examined in the lives of the women we have treated is different than what we see in men. This includes differences in etiological pathways of problem development; patterns of use; speed of problem progression; frequency, types, and severity of co-occurring medical and psychiatric disorders; obstacles to treatment; clinical issues during treatment; scope of service needs; prognosis for recovery; and styles of long-term recovery.

Relationships with other Women: Treatment is often the first opportunity addicted women have to break out of their historical pattern of distrusting and disliking other women. Treatment and linkage to the larger recovery community opens opportunities to develop safe, healthy relationships with strong, sober women.

Trauma: Developmental trauma (physical, sexual, emotional) is a dominant theme in the lives of many addicted women. Addiction recovery must be grounded within the larger process of healing such trauma.

Intimate Relationships: Trauma in the lives of addicted women is often recapitulated in their adult intimate relationships through a process that has been christened *assortative mating* (Vanyukov, Neale, Moss, & Tarter, 1996). Recognizing, managing, and then breaking these patterns are central recovery issues for many women.

Anger: It was previously thought that anger management was predominantly for the male patient. Today more women are self-identifying the need to work on anger management.

Body Image: The self-esteem of addicted women is closely tied to culturally-transmitted beauty myths that feed self-hatred, self-injury, and vulnerability for collateral eating disorders.

Sanctuary: The successful treatment of addicted women is contingent on creating physical and psychological safety within a healing community. Gender specific treatment units and gender specific groups allow women to bond and develop that environment of safety.

Spirituality and Strength: Recovery for women often involves discovery of previously hidden strengths and sources of power within the self. Discovery of these resources is enhanced through strengths-based assessment and counseling processes. The core of addiction treatment for women is the experience of empowerment: the acquisition of power through new knowledge, skills, and relationships.

Self-Discovery and Self-Acceptance: Recovery is about self-discovery (finding the authentic I) and self-acceptance (shedding expectations of perfection). It is also about transcending the shame-inducing social stigma that has long been attached to addicted women.

Balance: Recovery for women is often a balancing act between self-care and care giving for their intimate partners and children. Treatment must help nest recovery within the unique role demands placed on women at the same time it empowers women to challenge culturally-imposed role restrictions.

Family Healing: Addiction wounds all family subsystems; recovery involves a restructuring of intimate relationships, parent-child relationships, and sibling relationships. Family-centered treatment is a

crucial catalyst of such healing and helps all family members achieve and maintain healthy relationship boundaries.

Sustained Support: Recovery outcomes are enhanced through post-treatment recovery support such as is found in women's meetings in Twelve Step groups and in Twelve Step sponsorship, as well as in other recovery support groups/relationships. The goal of recovery is not independence, but healthy interdependence in relationships marked by continuity of mutual support.

Varieties of Recovery Experience: Women exhibit multiple pathways (religious, spiritual, secular) and diverse styles of long-term recovery. These pathways and styles are also influenced by age, ethnicity/culture, sexual orientation, developmental experience and family circumstances. Such diversity is a cause for celebration.

Gender-segregated Treatment: All of the authors have had sustained experience with both co-ed treatment and gender-segregated treatment. We believe the latter to be qualitatively superior and the source of the best long-term recovery outcomes for women.

We have personally and institutionally learned a great deal through the histories profiled in this article. Our best teachers have been the women whose recovery stories have touched and inspired us. They are the unsung heroes who have used their lives to write new chapters in the history of addiction recovery in America.

Acknowledgment: We would like to thank Missy Orlando, Sue Hoisington, Damian McElrath, and Barb Anderson for their assistance with this project.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2007). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at **www.williamwhitepapers.com**

In Search of the Neurobiology of Addiction Recovery: A Brief Commentary on Science and Stigma

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In 1997, Dr Alan Leshner, then Director of the National Institute on Drug Abuse (NIDA) published a seminal article, "Addiction is a Brain Disease, and It Matters," in one of the world's leading scientific journals (Leshner, 1997). That event was the opening salvo in a decade-long research and public education campaign to re-educate the public about the nature of addiction. The focus of this campaign has been to move "addiction is a disease" from the status of an ideological proclamation by policy activists and an organizing metaphor for individuals seeking to resolve alcohol and other drug problems to a science-grounded conclusion. The involvement of scientists was, in part, a response to earlier and continuing anti-disease polemics, e.g., *Heavy Drinking: The Myth of Alcoholism as a Disease* (Fingarette, 1989), *The Diseasing of America* (Peele, 1989), *The Myth of Addiction* (Davies, 1992) and *Addiction is a Choice* (Schaler, 2000). In the 1990s, the prolonged debate over disease conceptualizations of alcoholism and drug dependency moved from the philosophy departments to the scientific laboratories with the greatest financial investment in history in genetic and neurobiological studies of addiction. The fruits of that research triggered a campaign to re-educate the public and policy makers about the nature of addiction.

The "addiction is a brain disease" campaign has gained momentum in recent years. In a 2005 special issue of *Nature* entitled Focus on the Neurobiology of Addiction, a distinguished group of scientists assembled the latest evidence that addiction at its most fundamental essence is a neurobiological disorder. This was followed in May 2007, by Dr. Nora Volkov's[1] historic lecture, "The Neurobiology of Free Will," at the American Psychiatric Association's annual conference. This lecture signaled a maturing of the research community's understanding of addiction as a brain disease. Dr. Volkov described the most

[1] The present Director of the National Institute on Drug Abuse.

complex picture to date of how drugs compromise multiple regions of the brain and how these discrete effects collectively elevate continued AOD use as the supreme priority in personal decision-making—a priority that transcends other needs of the individual, his or her family, and society.

These findings have been communicated to the public via the metaphor of the "hijacked brain" in major media outlets--from Bill Moyers 1998 PBS special *Moyers on Addiction: Close to Home* to the 2007 HBO special *Addiction: Why Can't They Just Stop*?--and through popular magazines--*Time Magazine*'s July 16, 2007 cover story, "How We Get Addicted"). The National Institute on Drug Abuse has attempted to explain this brain hijacking process to the public as follows:

> *The initial decision to take drugs is mostly voluntary. However, when drug abuse takes over, a person's ability to exert self control can become seriously impaired. Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decisionmaking, learning and memory, and behavioral control. Scientists believe these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction.* (NIDA, 2007, p. 7.)

Many recovery advocates have celebrated these scientific discoveries and have helped promote programs like the HBO special that interpret this science to the public and policy makers. The purpose of this brief commentary is to talk about a crucial missing component in the addiction science agenda and in these public awareness programs. <u>Put simply, what is missing is recovery</u>.

I would suggest the following hypotheses:

1) communicating the neuroscience of addiction without simultaneously communicating the neuroscience of recovery and the prevalence of long-term recovery will increase the stigma facing individuals and families experiencing severe alcohol and other drug problems, and
2) the longer addiction science is communicated to the public without conveying the corresponding recovery science, the greater the burden of that stigma will be.

Shifting the public view of the etiology of addiction from one of volitional misconduct to a brain disease may not alter social distance between alcohol and drug dependent individuals and the larger citizenry. Campaigns that sought to reduce the stigma of mental illness by educating the public that mental illness was a brain disease inadvertently invoked perceptions that the mentally ill were less than human and invoked harsher behavior toward the mentally ill (Mehta & Farina, 1997; Corrigan & Watson, 2004). While such research has not been directly replicated in the addictions field, Crawford and colleagues (1989) did find that humanitarian attitudes toward the alcoholic (e.g., a sympathetic attitude and belief that treatment should be supported by public funds) were not directly related to whether alcoholism was or was not viewed as a disease.

The vivid brain scan images of the addicted person may make that person's behavior more understandable, but they do not make the person whose brain is being scanned more desirable as a friend, lover, spouse, neighbor, or employee. In fact, in the public's eye, there is short distance between the perceptual categories of brain diseased, deranged and dangerous. We should not forget that a century ago biological models of addiction provided the policy rationale for prolonged sequestration of addicted persons and their inclusion in mandatory sterilization laws (White, 1998). Further, christening addiction a CHRONIC brain disease—as I have done in innumerable presentations and publications, may, without accompanying recovery messages, inadvertently contribute to social stigma from a public that interprets "chronic"

in terms of forever and hopeless ("once an addict, always an addict")(See Brown, 1998 for an extended discussion of this danger).

Conveying that persons addicted to alcohol and drugs have a brain disease that alters emotional affect, compromises judgment, impairs memory, inhibits one's capacity for new learning, and erodes behavioral impulse control are not communications likely to reduce the stigma attached to alcohol and other drug problems, UNLESS there are two companion communications: 1) With abstinence and proper care, addiction-induced brain impairments rapidly reverse themselves, and 2) millions of individuals have achieved complete long-term recovery from addiction and have gone on to experience healthy, meaningful, and productive lives. Conveying these latter statements may not be as important to changing stigma as personally knowing one or more people in long-term recovery who have achieved such success, but such statements would establish a social climate in which addiction recovery could flourish and recovered and recovering people would have access to the opportunities and relationships available to other citizens.

So why don't the leading addiction scientists communicate findings related to the neurobiology of addiction recovery and the prevalence of long-term recovery? The reason would appear to be that the answers to these questions are not yet known—at least not at the same depth and certainty with which we are unraveling the neurobiology of addiction. There has been no guiding recovery research agenda to answer such questions. Preliminary studies on brain recovery from addiction following abstinence are very promising (e.g., Bartsch, Homola, Biller, et al, 2007) and recovery prevalence studies reveal rates of sustained remission higher than the public or treatment professionals would expect (Dawson, Grant, Stinson, et al, 2005; de Bruijn, van den Brink, Graaf, et al, 2006), but the neurobiology of recovery and the prevalence, pathways, styles and stages of long-term recovery remain the new frontiers of addiction research.

It is time to enter those frontiers. In the neurobiology arena, there are basic questions to be answered, including:

- To what degree does neurobiology influence who recovers from addiction and who does not achieve such recovery?
- What is the extent to which addiction-related brain pathology can be reversed through the long-term recovery process?
- What is the time period over which such pathologies are reversed in recovery—days, months, years?
- What role can pharmacological adjuncts, social support and other services play in extending and speeding this process of brain recovery?
- Are there critical differences in the extent and timing of neurobiological recovery related to age of onset of use, duration of addiction career, problem severity and complexity, age of onset of recovery, gender, genetic load for addiction, developmental trauma, ethnicity, primary drug choice, and other potentially critical factors?

We need a comprehensive recovery research agenda, and that agenda needs a strong component focused on the neurobiology of addiction recovery. The financial investment in a recovery research agenda is unlikely to be forthcoming without concerted advocacy. Every time an addiction scientist presents brain scans illustrating the neurobiology of addiction, a recovery advocate needs to be present to request the brain scans that illustrate the neurobiology of recovery.

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Toward a Philosophy of Choice: A New Era of Addiction Treatment

William L. White, MA

Being given choices of institutions, levels of care, treatment goals/methods, service personnel, and service duration has historically not been part of the personal experience of addiction treatment in the United States. This article describes why addiction treatment professionals have been reticent to offer choices to their alcohol and drug dependent clients and why that philosophy is now undergoing reevaluation.

Dr. Jekyl and Mr. Hyde

Addiction treatment has for more than 150 years been more a process of professional diagnosis, direction, and indoctrination than a process of guided self-reflection and self-change. Since the advent of program accreditation standards in the 1970s, clients entering addiction treatment have been asked to sign a treatment plan. This ritual has conveyed the illusion of participation and choice, but anyone familiar with the process knows that the choices available to clients have, until recently, been narrowly prescribed by each program's treatment philosophy, available levels of care, coercive dictates from referral sources, or by the external care managers who governed reimbursement decisions. Another factor concerning limited choice in addiction treatment is the perception that those entering addiction treatment have lost the power of choice—that the state of addiction is the very antithesis of choice (Michael Flaherty, personal communication).

Slogans heard within traditional treatment and recovery circles suggest that people addicted to alcohol and other drugs:

- Possess an elaborate cognitive defense structure (grandiosity, denial, minimization, rationalization, intellectualization, projection of blame, preoccupation with power and control) that seriously distorts reality

- Are incapable of honest self-perception and complex choice-making (e.g., *When you think you're looking good, you're looking bad*; *Your best thinking got you here*; *Keep it simple, stupid*; *First thing's first*).
- Cannot be relied upon to act in their own best interests (e.g., *An alcoholic is someone who finds something that works and then stops doing it*; *The three most dangerous words for the alcoholic—I've been thinking*).
- Best enter recovery through a process of submission and surrender (e.g., *Let go, Let God*; *Sit down, shut up, listen*; *When in doubt, act as if*; *Fake it 'til you make it*).

The problem with choice for the alcoholic/addict has often been framed as a problem of the split self. The question is, "Who's really choosing: Dr. Jekyll or Mr. Hyde?" How can we as professionals distinguish a client's authentic choice from what A.A. calls "stinkin' thinkin'", what Rational Recovery calls the addictive voice or "Beast," what Secular Organization for Sobriety refers to as the "lizard brain," what LifeRing Secular Recovery calls the "addict self" (versus the "sober self"), and what Christian recovery groups sometimes refer to as the "voice of the Devil"? If we offer each client enhanced choices, will it be the client or the disorder/devil making the decisions?

This treatment and recovery folklore has gained credence from recent scientific studies. In May 2007, Dr. Nora Volkov, Director of the National Institute on Drug Abuse, presented a historic lecture at the annual APA conference entitled the "The Neurobiology of Free Will" that signaled a turning point in the field's understanding of addiction as a brain disease. Dr. Volkov described the most complex picture to date of how drugs compromise multiple regions of the brain in ways that place continued AOD use as a priority over other best interests of the individual, family, and society (See also Nature Neuroscience, 2005). Based on the work of Volkov and other scientists, one could posit addiction as a disease of the will marked by a progressive loss of volitional control over AOD use and related decision-making. Unfortunately, work to date reveals very little about the neurobiology of recovery. There is much talk of hijacked brains (e.g., the erosion of executive function, the loss of inhibitory control, re-ordered motivational priorities), but the extent and timing of the reclamation of the will through the recovery process remains shrouded in mystery. Studies to date (e.g., Bartsch, Homola, Biller et al., 2007) show a good prognosis for

brain recovery associated with abstinence, but questions abound regarding the pace and extent of such recovery.

The Context for Choice

The factors limiting client choice in addiction treatment now face countervailing forces. The options available to those with AOD problems have never been greater, as reflected in the number of specialized and competing addiction service organizations, the availability of brief interventions, numerous evidence-based treatments (including new pharmacotherapies), the growth and diversification of addiction recovery mutual aid groups (including explicitly religious and secular alternatives to Twelve Step Programs), the availability of peer-based recovery support services, and the growing availability of Internet-based services (Humphreys, 2004; White, 2004; White, in press). There is also growing scientific evidence that many people resolve AOD problems without professional or peer assistance (Cunningham, Sobell, Sobell, et al, 1995; Granfield & Cloud, 1995). Today, individuals and families seeking help have choices that vary widely in setting, philosophy, service elements, service personnel, and costs.

There is growing awareness of the legitimacy of multiple pathways and styles of long-term recovery (White & Kurtz, 2006b). A new recovery advocacy movement is calling upon individuals and families to take responsibility for their own long-term recovery processes and to promote pro-recovery social policies and recovery-oriented systems of care (White, 2006). The need for informed consumers of addiction treatment is underscored by historical and scientific findings that:

- "Harm done in the name of help" has a long tradition in the history of addiction treatment (White, 1998).
- Many current mainstream treatment practices lack scientific evidence of their effectiveness, and others have been shown to be potentially harmful (Miller, Wilbourne, & Hettema, 2003; White & Miller, 2007).
- Treatments utilizing different philosophical foundations and therapeutic techniques can generate comparable treatment outcomes for adults (Project MATCH Research Group, 1998) and adolescents (Dennis, Godley, Diamond et al., 2004), but individual treatment programs and individual counselors vary widely in their recovery outcomes (McLellan, Grissom, Brill et al., 1993; McLellan, Woody, Luborsky, & Goehl, 1988).

- Responses to all recovery mutual aid groups vary, including individuals who fully respond, partially respond, and fail to respond (Morgenstern, Kahler, Frey, & Labouvie, 1996)—a finding that reinforces the importance of person-program fit.
- Client motivation and transfer of learning from therapeutic to natural environments is enhanced by client choice in the treatment and recovery support process (Miller & Rollnick, 1991).
- When given a choice, individuals tend to choose the goal that is most appropriate for them (Larimer et al., 1998).

The movement to expand client choice-making in addiction treatment is also being fueled by the development of new service technologies (e.g., motivational interviewing, contingency management, recovery coaching) that provide frameworks for facilitating client choice and the use of special aids to enhance recovery-conducive decision making (e.g., from pharmacological adjuncts to sustained professional and social support). It is in this context of expanded service options and new strategies for managing choice that calls are increasing to redefine the relationship between addiction professionals and those they serve from an expert relational model to a partnership-consultant model that provides stage-appropriate guidance and support (White, Boyle, & Loveland, 2002). And yet the question remains, "Would promoting expanded choices put clients in the driver's seat when, according to some therapeutic philosophies, that is exactly the position they need to abandon?"

Choice and the Stages of Recovery

One way to partially reconcile the dilemma between the traditional and emerging views of choice is to first acknowledge that free will in addiction and recovery is not an all or none phenomena. The capacity for volitional control over AOD use and related decisions is variable across individuals (as a function of the interaction between problem severity/complexity and recovery capital) and is dynamic (shifts incrementally on a continual basis within the same individual through both addiction and recovery processes). Recovery can be viewed as progressive rehabilitation or reclamation of the will—the power to reclaim personal choice (Smith, 2005). There are times the recovery process may involve consciously not choosing—relying on resources and relationships outside the self, and times that the next recovery steps require an assertion of self. At a practical level, this means that the first hours of acute detoxification are

not the best time to rely exclusively on client choice. And yet long-term recovery is not possible without choice. If there is no rehabilitation of the power to choose and encouragement of choice, we are left with, not sustainable recovery, but superficial treatment compliance.

To effectively apply a philosophy of choice requires great skill on the part of the addiction professional, particularly where a client's immaturity, cellular craving, impulsivity, psychiatric symptoms, and impaired judgment severely limit choice generation, choice analysis, and the capacity to stick with any personal resolution. In such cases, we must carefully plot a path between complete autonomy (total choice and clinical abandonment) and paternalism (no choice and intrusive control). Most clients have a sense of this need as well. Studies have shown that people with severe alcohol problems, perhaps recognizing their impaired decision-making capacities, prefer therapist-set goals in treatment, whereas those with less severe problems prefer self-set goals (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992). I suspect mismatches in the degree of choice allowed in the treatment process (both ill-timed episodes of too much and too little choice) contribute to high rates of treatment non-completion via clients leaving against staff advice and clients being administratively discharged.

Implementing a Choice Philosophy.

One of the most important arenas of choice within addiction treatment involves broad frameworks of recovery. The choice philosophy is based first on the recognition of multiple (secular, spiritual, and religious) pathways and styles of long-term recovery and the recognition of the right of each person to select a pathway and style of recovery that represents their personal and aspirational values. Steps that addiction treatment programs can take to actualize a philosophy of choice related to recovery pathways are illustrated in Table 1.

Table 1 **Actualizing the Choice Philosophy Related to Recovery Pathways**
• Addiction counselors, recovery coaches, and volunteers represent the diversity of pathways and styles of personal/family recovery. • Addiction counselors and recovery coaches are knowledgeable about the full spectrum of religious, spiritual, and secular

- Addiction counselors and recovery coaches are aware of common patterns of co-attendance (concurrent or sequential participation in two or more recovery support structures).
- Individuals and their families are educated about the variety of recovery experiences and the legitimacy of multiple pathways and styles of recovery.
- Informational materials, lectures, and structured exercises that people receive represent the scope of recovery support options, e.g., posting all local recovery support meeting schedules on the treatment agency website and facility bulletin boards, giving each client a wallet card with the central contact numbers of local recovery support groups, profiling local recovery support groups in agency/alumni newsletters.
- Individual choice is respected; individuals receiving services are not demeaned or disrespected for the recovery support strategies they choose; clinical strategies involve motivational interviewing principles and techniques rather than coercion and confrontation.
- Addiction counselors and recovery coaches are encouraged to self-identify negative feelings they may have about a particular pathway of recovery chosen by a client and discuss such feelings in the context of clinical supervision. (Adapted from White & Kurtz, 2006a)

Creating Informed Consumers

A philosophy of choice is viable only with persons who have the neurological capacity for decision-making, who believe they have the right to make their own choices, and who are aware of and can evaluate available service and support options. Creating informed, assertive consumers of addiction treatment and recovery support services can be enhanced by: 1) affirming the service consumer's right to choose, 2) distributing and reviewing consumer guides on treatment and recovery support services published by local recovery advocacy organizations, 3) teaching service consumers how to recognize quality treatment services and healthy support groups, 4) informing consumers about the potential of harmful side effects

of treatment and mutual aid group participation, 5) encouraging consumers to visit and sample service/support options, 6) defining the criteria by which the client and service specialist will know if participation in a particular activity is working or not working, and 7) monitoring each client's responses to treatment and support services (Bev Haberle, Personal Communication, 2007). Similar considerations need to be extended to educate the family members of those needing or seeking recovery.

Choice and Limited Resource Alternatives

A major obstacle to implementing a choice philosophy remains the limited recovery support options available today within many communities. Altering that situation requires moving from a clinical perspective to a recovery community development perspective. Recovery options are expanding, clients are using these options (either alone or in patterns of co-involvement with one or more support groups), and progressive treatment organizations are playing a role in nurturing the development of expanding recovery support resources (White, 2007). The internet is also bringing expanding treatment and recovery support services into many previously resource deficient communities. The choice philosophy only has meaning where legitimate alternatives exist for treatment and recovery support.

A Closing Reflection

A day is coming when each client seeking help for the resolution of AOD problems will be given a menu of service and support options. This menu will include the best scientific evidence drawn from national and international studies on the degree of effectiveness of the respective menu options. When that day arrives, each client, family, and referral source will also have the right to review standardized, recovery-focused performance measures for each treatment institution, each method of treatment, and each addictions professional. Our struggles today with the question of choice may mark the dawn of that coming day.

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Acknowledgement: Portions of this article have been excerpted/adapted from White, W. & Kurtz, E. (2006). *Linking addiction treatment and*

communities of recovery: A primer for addiction counselors and recovery coaches. Pittsburgh, PA: Institute for Research, Education and Training in Addictions. A free download or purchase of a hard copy of this monograph is available at http://www.ireta.org/store/customer/home.php?siteversion=ireta.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Passetti, L. L., & White, W. L. (2007). Recovery support meetings for youths: Considerations when referring young people to 12-step and alternative groups. *Journal of Groups in Addiction and Recovery*, 2, 97-121. Posted at **www.williamwhitepapers.com**

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Abstract

Participation of young people in recovery support meetings is a promising yet largely understudied area. This article reviews the history of youth involvement in meetings, provides rationale for enhancing participation, summarizes current research, and discusses issues professionals may want to consider when making referrals. Based on information covered, professionals may want to research local meetings, help young people structure time before and after meetings, become familiar with group customs, investigate a variety of support groups, interact with support group service structures, develop a list of reliable group members to connect youths to the recovering community, and implement assertive referral strategies.

Keywords: Recovery support groups; 12-step; adolescent

Preparation of this manuscript was supported by funding from the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services through the Strengthening Communities-Youth project (grant no. TI13356) and the National Institute on Drug Abuse, National Institutes of Health (grants no. 1 RO1 DA 018183 and 5 F31 DA17406 03). The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services or the National Institutes of Health. The authors wish to acknowledge the support of CSAT project officers, Randy Muck and Jutta Butler. The authors also want to acknowledge feedback from Susan Godley and Mark Godley on drafts of this manuscript. For further information about this paper, please contact Lora Passetti at 309-827-6026, x.3316 or at lpassetti@chestnut.org.

Participation of young people in recovery support meetings is a promising yet largely understudied area in the field of substance abuse research. The purposes of this article are to: 1) review the history of youth involvement in recovery support meetings; 2) provide a rationale for enhancing youth participation; 3) summarize

current research on young people and recovery support groups; and 4) discuss issues professionals may want to consider when referring youths to 12-step and alternative groups, including strategies for linking young people to meetings. Much of this paper will focus on Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) because of their historical longevity, membership size, geographical dispersion and availability, and the number of scientific studies of their effects on long-term recovery outcomes.

History of Youth Involvement in Recovery Support Meetings

Professionally-directed and peer-based support structures for young people seeking recovery from severe alcohol and other drug problems have evolved over the past two centuries in tandem with youthful substance use trends (White, 1999). Nineteenth century recovery-support societies such as the Washingtonians and the Ribbon Reform Clubs sponsored "cadet" branches for young inebriates and launched "youth rescue" crusades (White, 1998). Many leaders of these efforts started their own downfalls as youth, one of whom even became known on the temperance lecture circuit as the "saved drunkard boy" (Foltz, 1891). Young people were admitted to nineteenth century inebriate homes, inebriate asylums and private addiction cure institutes, but there was no specialized adolescent treatment, nor youth-focused branches of such institutional aftercare groups as the Keeley Leagues (White, 1998). Alcohol problems among young people waned in tandem with the growth of the American temperance movement.

The heroin epidemic of the early twentieth century spurred rising juvenile arrests, the rejection of thousands of World War I draftees, and the admission of adolescents to morphine maintenance clinics that operated in 44 communities between 1919 and 1924 (Terry and Pellens, 1921). Of the more than 7,500 addicts registered at the Worth Street Clinic in New York City, 743 were under the age of 19 (Hubbard, 1920), but there is no record of any peer-based recovery support structures linked to these clinics. This lack of specialized recovery support resources continued as admissions of persons under age 21 to the two federal "narcotics farms" rose from 22 in 1947 to 440 in 1950. The dramatic rise of juvenile narcotic addiction in New York City in the early 1950s led to increased admissions to local hospitals (New York Academy of Medicine, 1953) and the 1952 opening of America's first specialized addiction treatment facility for juveniles—Riverside Hospital. The eventual closure of Riverside in 1962 following studies confirming 95%+ post-treatment relapse rates led some to speculate that the Achilles heel in the Riverside Hospital design was its inability to transfer institutional learning to the natural environment of those it treated (Gamso and Mason, 1958).

Peer-based recovery support structures for young people in the mid-twentieth century rose from three sources: AA, adaptations and alternatives to AA, and faith-based recovery ministries.

Young People's Groups in AA ("young people" then defined as AA members under age 35) began in the 1940s in cities such as Cleveland (1944), Los Angeles (1945), Philadelphia (1946), New York City (1947), and San Diego (1948). These increased through the 1940s to the point they commanded a special section of the 1950 International Convention of AA. In 1958, the growing network of Young People's Groups formed the International Conference of Young People in Alcoholics Anonymous and hosted their first convention in Niagara Falls, New York. That annual event now draws more than 3,000 young AA members from all over the United States (Special Composition Groups in A.A., 2002).

Young People's Groups were started in AA to escape the status very young members had as curiosities. The first *AA Grapevine* articles on young people in AA were published in the late 1940s under such titles as "Young Men Solve Meeting Problems" and "A Plea for the Young in Years," and the number of such articles grew significantly in the 1960s and 1970s. Over

that span, ages of "young AA members" dropped from the 30s into the early twenties and then into the teens. A review of articles on young people in AA published in the *AA Grapevine* between 1948 and 1978 reveals that the young people who entered AA in these years faced incredulity and suspicion ("You're too young to be an alcoholic!"), condescension and disdain ("I've spilled more booze than you've drunk."), criticism ("We don't want to hear about those other drugs."), or were fawned over ("You are so lucky to have come to AA so young!"). A review of similar articles over the past 25 years reveals that such attitudes weakened as the average age of AA members progressively declined. In 1994, a regular feature of the *Grapevine* ("Youth Enjoying Sobriety") was begun that focused on young people in AA. Between 1948 and 2006, more than 100 articles have appeared in the Grapevine that focused on young people recovering within AA (B. Weiner, personal communication, November 30, 2006). Alateen, founded in 1957, also served as a source of support for adolescents who struggled with the alcoholism of a parent and a pathway of entry into recovery for some of these young people who went on to develop similar problems in their teen years.

Several things contributed to the rise of young people and very young adolescents entering AA. Lowered age of onset of regular alcohol and other drug use in the United States and the trend toward multiple drug use have accelerated the development of severe alcohol and other drug problems and triggered help-seeking at ever younger ages. Increased public awareness of alcohol and other drug (AOD) problems and resources to resolve them along with reduced stigma may have increased the flow of young people into AA. The growing representation of youths may also signify a cumulative effect of young people in AA carrying a message of hope to others their age experiencing AOD problems and the growth of adolescent treatment programs that link their clients to AA for post-treatment recovery support. AA has also made an effort to reach out to young people through youth-oriented pamphlets (*Young People and AA*, *Too Young?*) and a film (*AA and Young People*). Young people's meetings can be located by contacting local AA Intergroups via the local AA telephone listing to request a meeting directory; statewide activities of young people in AA can be identified on the state conferences of young people in AA web sites (see www.e-aa.org/links/index.php?PID=9).

Other adaptations of AA's 12-step recovery program have attempted to reach out to young people. NA has attracted young people since its founding in the late 1940s and early 1950s. In 2005, there were over 21,500 registered NA groups holding over 33,500 meetings weekly. The birth of Potsmokers Anonymous (1968), Pills Anonymous (1975), Chemically Dependent Anonymous (1980), Cocaine Anonymous (1982), Heroin Anonymous, and Crystal Meth Anonymous reflect the continued evolution of AOD problems in America and the 12-step adaptations that have risen in response to them. There has also been a growth in secular alternatives to Twelve Step programs. The former include Women for Sobriety (1975), Secular Organization for Sobriety (1985), Rational Recovery (1986), Self Management and Recovery Training (SMART) (1994) and LifeRing Secular Recovery (1999). Explicitly religious approaches to addiction recovery include Alcoholics Victorious (1948), Alcoholics for Christ (1976), Overcomers Outreach (1977), Liontamers Anonymous (1980), and such recent groups as Ladies Victorious and Celebrate Recovery. Organizations such as Teen Challenge provide a religious alternative to secular treatment but have not generated autonomous, peer-based recovery support groups analogous to those linked to AA and NA.

This diversification of recovery support groups has not resulted in sufficient growth to create the equivalent of AA's Young People's groups, although such youth-oriented tracks could appear in the future. Queries to groups listed in the recovery mutual aid guide posted at the Faces and Voice of Recovery website (www.facesandvoicesofrecovery.org/resources/support_home.php) revealed only "a few" young people's NA meetings and one

designated young people's meeting (Holland, Michigan) in Alcoholics Victorious. The first recovery support group organized specifically for adolescents in recovery is Teen-Anon (1999). Teen-Anon, affiliated with the California-based Streetcats Foundation for Youth and the National Children's Coalition, has variations of its program for Christian teens, Jewish teens, and lesbian, gay and bisexual youth.

Rationale for Enhancing Youth Involvement

Following addiction treatment, most adolescents struggle with recovery and relapse. High relapse rates have been reported during the first 90 days after discharge from treatment (Brown, Vik, & Creamer, 1989; Dennis et al., 2004; Godley, Godley, & Dennis, 2001; Kennedy & Minami, 1993). Participation in professionally-directed continuing care groups can enhance substance use outcomes, but a substantial proportion of youths do not attend them unless assertive approaches that transfer responsibility of linkage and retention from the client to the clinician are employed (Godley, Godley, & Dennis, 2001; Godley, Godley, Dennis, Funk, & Passetti, 2002; Godley, Godley, Dennis, Funk, & Passetti, 2006).

Community-based groups are another potential source of recovery support for youths that can complement acute care interventions (Humphreys et al., 2004). As a free resource available in many communities, such groups can provide reminders of the negative consequences of substance use and the benefits of abstinence. Members offer experientially-based advice, are available 24 hours a day, and provide encouragement and opportunities for substance-free social events and interactions (Kaskutas, Bond, & Humphreys, 2002; Kelly, Myers, & Rodolico, in press). Such potential benefits merit further attention for youths.

Current Research on Youth Involvement in Recovery Support Meetings

The vast majority of research related to recovery support meetings has been conducted with adults attending 12-step-oriented groups, and a substantial body of published work supports the clinical practice of referring adults to 12-step meetings, recommending regular attendance, and encouraging involvement (Bond, Kaskutas, & Weisner, 2003; Connors, Tonigan, & Miller, 2001; Humphreys et al., 2004; Kissin, McLeod, & McKay, 2003; McKellar, Stewart, & Humphreys, 2003; Moos & Moos, 2004). On the other hand, research aimed at examining the effects of support group involvement on treatment and recovery outcomes for youths is still in its beginning stages. Studies have focused on youth participation in 12-step meetings, and no published studies of involvement in alternative groups were identified for this review.

The handful of existing studies designed to explore the helpfulness of young people's involvement in 12-step groups shows promise in this approach. To date, they indicate that adolescents who attend AA and/or NA after residential substance abuse treatment are more likely to remain abstinent, engage in less frequent substance use, and have better post-treatment outcomes than those who do not (Alford, Koehler, & Leonard, 1991; Brown, Mott, & Myers, 1990; Hsieh, Hoffman, & Hollister, 1998; Kelly & Myers, 1997; Kelly, Myers, & Brown, 2000; Kelly, Myers, & Brown, 2002; Kennedy & Minami, 1993). Two of these studies identified self-help meeting attendance as one of the most powerful discriminators of abstinence from substances up to 6 and 12 months after discharge (Hsieh, Hoffman, & Hollister, 1998; Kennedy & Minami, 1993).

In their review of the literature on adolescent participation in AA and NA, Kelly & Myers (in press) suggest that while evidence is starting to accumulate that youths may benefit from participation in 12-step groups, conclusions on this subject are limited in four main ways: 1) only a small number of studies have been conducted; 2) all known published research has concentrated on adolescents discharged

from residential or inpatient treatment, but no studies have yet examined 12-step involvement with adolescents treated in an outpatient setting; 3) research designs have been purely observational in nature, restricting the ability to make judgments about the effectiveness of youth participation in 12-step meetings**;** and 4) the 12-step construct has largely been measured in terms of attendance, pointing toward the need for additional information related to other dimensions of involvement, such as sponsor utilization, reading and comprehension of 12-step literature, and youths' understanding of the steps and how they are worked. Kelly & Myers (in press) advocate that future research studies include outpatient populations, focus on comparative efficacy and effectiveness studies of youth involvement in 12-step programs, better measure the 12-step construct, enhance understanding of developmentally-specific barriers to participation, include process studies to inform practice guidelines for professionals, collect more data regarding the frequency, spacing, intensity, and duration of 12-step participation by youths, and testing of 12-step facilitation efforts for adolescents.

Complicating efforts to maximize the benefits of youth attendance at recovery support meetings is the fact that**,** as with adults (Galaif & Sussman, 1995), a large number of adolescents who begin going to 12-step meetings eventually stop. One study revealed that the percentage of adolescents reporting attendance at one or more 12-step meetings dropped from 75% at 3-months post-residential discharge to 59% at 6-months (Kelly, Myers, & Brown, 2000). Another study discovered that 60% of adolescents in residential treatment attended 12-step meetings during the first 3 months after discharge, but only 38% did so at 12-months (Kennedy & Minami, 1993). In one sample, the odds that adolescents who discontinued 12-step meeting attendance used substances was almost three times that of those who kept going. Youths who dropped out were also about one-third more likely to report substance-related problems (Kelly & Moos, 2003).

Adolescents who are more likely to attend 12-step meetings and/or to become involved with them tend to present for treatment with more severe substance abuse problems (Kelly, Myers, & Brown, 2002), have friends who use little to no substances, have been admitted to treatment more than once, experience more feelings of hopelessness, and receive less family participation in their treatment (Hohman & LeCroy, 1996). Further evidence suggests that professional 12-step inpatient programs facilitate AA and/or NA participation immediately following treatment for a number of clients, at least in the short-term (Kelly & Myers, in press; Passetti & Godley, 2007).

Results from another recent study that observed adolescents discharged from residential substance abuse treatment indicate that they, as a whole, perceived AA and/or NA to be important and helpful in their recovery, yet just over 1 in 4 perceived participation to be of little or no importance. On average, they felt connected to these recovery support groups, yet approximately 1 in 5 reported little or no feeling of connection to them. Aspects of AA and/or NA that youths reported liking the most were general group dynamic processes related to universality, support, and instillation of hope. The most common reasons adolescents reported for dropping out of 12-step groups included boredom, lack of fit with the group, and relapse. To a lesser extent, lack of perceived need to continue, low motivation, and the removal of external pressures to attend were also mentioned. The authors concluded that general group therapeutic factors, not 12-step specific ones, were most valued by adolescents during early stages of recovery and AA and/or NA exposure (Kelly, Myers, & Rodolico, in press).

Given the promise yet inconclusiveness of current research in the area of youth 12-step group involvement, providing clear recommendations for professionals working with youths experiencing substance abuse problems is challenging. Several issues, concerns, and barriers to the participation of young people have been raised in the literature or

anecdotally by professionals and are raised below for further consideration.

Issues to Consider When Referring Youths to 12-Step and Alternative Support Groups

Potential iatrogenic effects of group interventions. One concern articulated in the literature on group interventions with youths is the potential of peers to contribute to the escalation of problem behaviors among young adolescents through "deviancy training." Data from some research conducted with at-risk youths suggested that certain peer-group interventions unintentionally increased adolescent problem behavior and negative life outcomes in adulthood under some circumstances (Dishion, McCord, & Poulin, 1999; Dishion, Poulin, & Barraston, 2002), consequences which may be impacted by the characteristics of participants, the skill of group leaders, and the intervention context (Dishion & Dodge, 2005; Gifford-Smith, Dodge, Dishion, & McCord, 2005). Importantly, these studies focused on preventive interventions for at-risk youth who were in pre- or early adolescence and had not yet developed a substance use disorder (Burleson, Kaminer, & Dennis, 2006).

Research with adolescents who have already developed substance use disorders has failed to identify peer contagion effects of group interventions. For example, Waldron and colleagues (2001) did not find negative outcomes for the group intervention included in their randomized trial of 4 substance abuse treatment models. Results from the Cannabis Youth Treatment (CYT) experiment (Dennis et al., 2004) indicated that all three group therapy conditions were associated with reduced substance use and problems during treatment and a follow-up period. Relative to individual and family interventions, there was no evidence of iatrogenic effects from group treatment in one of the largest randomized trials of adolescent substance abuse treatment. Additional examination of CYT data revealed that the composition of group members in terms of conduct disorder symptoms was not associated with worse substance use, psychological, environmental, or legal treatment outcomes. In fact, there was a slight advantage for youths with conduct disorder to be included in groups consisting of members with less severe symptoms. No results suggested that youths presenting with less severe conduct disorder failed to improve on outcome measures when exposed to youths with more severe symptoms, supporting the idea that group therapy for adolescents with substance use disorders is safe and effective (Burleson, Kaminer, & Dennis, 2006). Finally, a review of 66 studies by Weiss et al. (2005) did not discover any real evidence of systematic iatrogenic effects of group treatment of antisocial youths over the age of eleven.

These findings demonstrate that group interventions run by clinicians may not have negative effects on young people solely by virtue of the fact that they contain other youths with substance use disorders and behavioral problems. Recovery support meetings, however, are not traditionally run by professionals and are frequently comprised of mostly adults. Anecdotally, some clinicians have expressed apprehension about adolescents' attendance at 12-step meetings dedicated to youths. Issues of concern included the discovery of drug dealing at one youth meeting as well as the tendency for those groups to consist of a large gathering of newcomers (i.e., those without long-term sobriety), both circumstances that may test youths' ability to remain clean and sober. Young people who tend to make poor relationship choices could also form inappropriate relationships with other individuals, adult or adolescent, in meetings (Passetti & Godley, 2007).

Professionals who refer youths to recovery support groups may want to consider working with parents and caregivers to structure and supervise youths' time before and after meetings to minimize the opportunity for negative interactions. Caregivers and professionals may also want to closely monitor attendance experiences and contacts made with other group members. No detailed research investigating potential harmful effects of

same-aged or older recovery support group members on youths has been published, but some studies have investigated how the age composition of recovery support groups may impact youth attendance rates and outcomes.

Age composition of recovery support group meetings. While 12-step-oriented treatment approaches and referrals of youths to recovery support meetings are prevalent (Drug Strategies 2003; Jainchill, 2000), recent membership surveys of three common 12-step support groups reveal that less than 3% of their members are under the age of 21 (Alcoholics Anonymous, 2005; Cocaine Anonymous World Services, 2006; Narcotics Anonymous World Services, 2005). Rates of youth membership in 12-step alternative support groups are largely unknown, but a survey of LifeRing members indicated that less than 1% were under the age of 20 (LifeRing, 2005). Even though meetings dedicated to youths exist in some (but not all) communities, these statistics suggest that typical 12-step meetings consist largely of adults. Furthermore, Kelly and Myers (1997) found that 65% of the 12-step meetings attended by adolescents in that study were comprised mainly of older individuals. Such findings are meaningful because the substance use patterns and related problems of adults often differ from those of youths. For example, adolescents in treatment tend to use multiple substances concurrently and experience fewer medical complications, fewer withdrawal symptoms, and significantly shorter histories of substance abuse than adults (Brown, 1993; Stewart & Brown, 1995). They also tend to have less substance abuse problem recognition and motivation for abstinence (Tims et al., 2002). Adults may face difficulties related to loss of employment, loss of housing, and troubled relationships with spouses and children that youths cannot always identify with in their own lives.

Practice guidelines released by the American Psychiatric Association (1995) advise that young people generally function better in groups that consist of age-appropriate peers in addition to older members and that clients most likely benefit from groups containing individuals of similar age. Interviews with 30 clinicians employed in eight adolescent substance abuse treatment programs across the country revealed that age composition of group members was one of the most common factors considered when referring adolescents to 12-step meetings (Passetti & Godley, 2007). Research conducted to date supports the belief that those youths who attend meetings with at least a substantial proportion of adolescents after inpatient treatment have significantly better substance use outcomes (Kelly & Myers, 1997; Kelly, Myers, & Brown, 2005), higher frequency of attendance, and greater perceptions of the importance of meeting attendance. Greater age similarity, however, was not found to be related to the increased likelihood of having a sponsor or engaging in social activities with other 12-step group members (Kelly, Myers, & Brown, 2005). Additionally, while interviews with clinicians indicated that they perceived adolescents to have difficulty relating to adults, a few mentioned that some youths seemed to prefer adult meetings for the wisdom and praise that could be received from older individuals (Passetti & Godley, 2007).

Based on this information, professionals referring youths to recovery support meetings may want to locate groups dedicated specifically to young people or that attract larger percentages of youths in an effort to maximize attendance, involvement, and substance use outcomes. Some clinicians have noticed that young people tend to like NA more than AA because it attracts a younger and more diverse crowd (Passetti & Godley, 2007). Professionals may benefit youths by speaking with them about their comfort level at meetings consisting mainly of adults and by recognizing that some youths could opt to attend a mixture of meetings, i.e., some with all youths, some with mostly youths, and some with mostly adults; however, meetings dedicated to young people are not available in all communities. Additionally, professionals may want to emphasize that other adolescents have benefited from

support groups by feeling less lonely and more supported in their recovery efforts.

Ability of youths to understand and/or "buy into" program concepts. Related to the issue that young people may not relate well to adults is the concern that youths may have difficulty understanding and embracing ideas framed in adult language in recovery support groups, especially ones grounded in the 12 steps. Concepts such as "acceptance," "surrender," and "spirituality" in 12-step programs are suspected to be too abstract for adolescents to grasp (Deas & Thomas, 2001; Passetti & Godley, 2007). Due to their relatively short substance use histories, youths may also find it problematic to admit powerlessness over alcohol or other drugs and commit to lifelong abstinence, especially if they do not meet criteria for substance dependence (Passetti and Godley, 2007).

Little systematic investigation has explored how young people perceive and interpret common concepts in recovery support groups. Preliminary results from qualitative interviews with adolescents in residential substance abuse treatment indicate that some young people acknowledge feelings of powerlessness over substances and recognize that their lives are unmanageable. For example, certain adolescents experienced loss of control over substance usage, school or work problems, strained relationships with other people, and substance-related legal involvement. The idea of "hitting bottom" was harder to identify with, and some youths interviewed struggled with spirituality and comprehending 12-step literature. Steps related to making a fearless moral inventory and direct amends to people harmed were sometimes perceived as confusing or even frightening (Passetti, 2006). Interestingly, adolescents participating in the research presented by Kelly, Myers, & Rodolico (in press) did not report that the spiritual content of 12-step meetings was one of the main reasons for stopping attendance. On the other hand, 12-step-specific content was not a major reason for attending meetings early in the recovery process either. Both of these studies focused on youths admitted to residential treatment who tend to have more severe substance use histories than those admitted to less intensive treatment modalities; therefore, no conclusions can be drawn about the perceptions of young people with less severe substance use problems.

Since certain recovery support program concepts may be difficult to understand for some adolescents, professionals may want to review the language, concepts, and practices in those programs in order to prepare youths for what to expect during meetings (Forman, 2002) as well as to correct any misconceptions. Youths can be encouraged to discuss any concerns, confusion, or anxiety with other group members or sponsors.

Severity of youths' substance use and related problems. In one study, clinicians working in adolescent substance abuse treatment programs were more likely to refer youths to 12-step meetings if they presented with a high severity of substance use or were diagnosed with substance dependence rather than abuse. If adolescents demonstrated problems with substance use over a period of time or experienced serious or numerous consequences from their use, they were referred more frequently. A history of prior substance abuse treatment admissions and a greater openness to admitting that substance use was problematic also helped some clinicians determine that referrals were appropriate (Passetti & Godley, 2007).

While a previously discussed study indicated that adolescents with more severe substance use problems were more likely to attend 12-step meetings (Kelly, Myers, & Brown, 2002), no research has confirmed or refuted the idea that youths with less severe substance use problems do not benefit from recovery support groups, and debate on this issue exists. Passetti & Godley (2007) reported differing views articulated by various clinicians. Some felt that many adolescents will not go on to have lifelong issues with substances and that stories heard during 12-step meetings would be sensationalized. Others believed that

exposing youths to 12-step groups could help them to explore the ideas of powerlessness and acceptance and to feel more comfortable accessing recovery support groups in the future if needed. Furthermore, adolescents may hear other people's stories and realize that their substance use was more serious than they originally thought. Even though future research is needed in this area, the cultures of recovery support fellowships, networks, and associations may provide additional guidance for professionals referring youths with varying levels of substance abuse severity to meetings.

Cultures of recovery support fellowships, networks, and associations. When making referrals to recovery support groups, professionals would benefit from becoming familiar with the models from which they operate (Laudet, 2003), the activities in which members engage (Chappel & DuPont, 1999), and the subcultures that might exist (Holleran & MacMaster, 2005). In the case of AA or NA, knowledge of the 12 steps and 12-step concepts would enable professionals to speak knowledgeably to youths and to make the most informed referrals. Acquiring and reading group literature, visiting groups' internet sites, attending open meetings, and speaking with group members facilitate the process of learning group rules, concepts, language, and activities and the identification of group principles and guidelines, including membership requirements (White & Kurtz, 2006). For example, the only requirement for membership in AA is a desire to stop drinking (Alcoholics Anonymous World Services, 1972). If youths are not sure that they have a drinking problem or are reluctant to commit to abstinence, referrals to open meetings rather than closed ones may be more appropriate.

Familiarity with the variety of recovery support groups offered is important as well (Chappel & DuPont, 1999; Laudet & White, 2005; White & Kurtz, 2006). Not every youth will like 12-step meetings, and as established earlier, many stop attending over time. Some youths may find attending more than one type of group meeting helpful. By knowing about existing alternatives, professionals can provide youths with a menu of options for ongoing recovery support. Links to several mutual support groups can be found at the Faces and Voices of Recovery website mentioned earlier.

Cultures of local recovery support group meetings. In addition to knowledge about different support groups, information about specific meetings of those groups can help guide referral practices. Significant variation exists among individual support group meetings within the same fellowship, network, or association, both across and inside geographic regions (Montgomery, Miller, & Tonigan, 1993). Differences in cohesiveness, independence, aggressiveness, and expressiveness have been found between AA meetings as well as differences in the perceived amount of focus on working the steps and the 12-step program (Tonigan, Ashcroft, & Miller, 1995). One meeting is not necessarily like another.

Since recovery support group meetings can differ greatly from one another, professionals may benefit youths by gathering information about particular meetings in youths' communities and then using this data to match an individual young person with particular meetings based on needs, preferences, and cultural background (Humphreys et al., 2004; Laudet, 2003; Passetti & Godley, 2007). Important considerations may include which ones have young participants, consist of members with long-term abstinence, have adult members that welcome young people, or have members that other youths have identified with previously (Passetti & Godley, 2007). For certain youths, the number of people that normally attend, a smoking or non-smoking designation, and/or substance of choice of group members may help determine which meeting to recommend. Other youths may be interested in meetings dedicated to certain groups of people based on gender or sexual orientation, speaker or discussion meetings, and/or meetings devoted to discussions of particular steps or traditions in 12-step oriented groups

(Forman, 2002; Passetti & Godley, 2007). In the case of AA, it may be relevant to know which meetings are more or less tolerant of individuals who are dependent on substances other than alcohol (Passetti & Godley, 2007). Youths may need to be encouraged to try a variety of meetings before finding ones that they feel the most comfortable attending (Caldwell, 1998; Passetti & Godley, 2007).

Professionals can learn about the cultures of local recovery support group meetings in several ways. Colleagues and staff members of local substance abuse treatment agencies, particularly those who have identified themselves as recovering, may be valuable sources of information about local recovery support groups (Chappel & DuPont, 1999; Passetti & Godley, 2007). Youths with prior meeting experience can provide insights from their perspectives (Passetti & Godley, 2007). Additionally, professionals not in recovery may want to attend open meetings in targeted communities to become familiar with the dynamics of those specific groups.

The ability to recommend certain meetings for youths depends on the availability and accessibility of meetings in a given area. Urban and suburban regions will more likely have a range of options than small towns and rural locations. If a youth lives in a small town with only one adult AA meeting and has no transportation, choices are limited without creative intervention. School and employment schedules and curfews may also impact which meetings youths are able to attend. A lack of available recovery support meetings for adolescents in some geographical areas is triggering interest in telephone-based and internet-based recovery support services (Skinner et al., 2001; Kaminer & Napolitano, 2004). A helpful guide to such online recovery support groups can be found at the Faces and Voices of Recovery website.

Working with recovery support groups to connect youths to the recovering community. Most recovery support groups have service structures and procedures governing relationships with treatment organizations and other institutions. In AA, Hospitals and Institutions Committees or Treatment Facilities Committees work with organizations to bring meetings into facilities, encourage participation, coordinate temporary contact programs, and help arrange the purchase and distribution of literature (Alcoholics Anonymous, 2007). Other 12-step groups typically have similar structures in place (White & Kurtz, 2006). When working with youths, professionals may decide to contact such committees to facilitate involvement in the recovering community. Committee members may also be willing to help start meetings dedicated to youths if they do not exist in a certain area.

Assertive linkage versus passive referral. In adult populations, assertively linking individuals to recovery support groups has proven to be a more successful strategy than passively recommending them to attend (White & Kurtz, 2006). Assertive linkage procedures may involve early referral to support groups, education about the potential benefits and risks of meeting attendance, ongoing monitoring of involvement and obstacles, and discussion of each person's prior experiences with, responses to, and perceptions of participation (Laudet; 2003; Ogborne, 1989; White & Kurtz, 2006). One study demonstrated that directly connecting someone to a 12-step group representative, rather than only providing meeting information and verbal encouragement, increased 12-step group attendance (Sisson & Mallams, 1981). While another study did not find greater attendance rates, referral procedures that proactively introduced adults to 12-step group volunteers, addressed concerns, set attendance goals, and encouraged finding a sponsor and a home group fostered greater participation in 12-step activities. Those adults that received this intervention demonstrated significantly higher abstinence rates from substances other than alcohol than those who did not, and those with less previous meeting attendance were more likely to attend a greater number of meetings (Timko, DeBenedetti, & Billow, 2006).

There have been additional recommendations to incorporate

motivational interviewing principles into efforts to link individuals with support groups. A focus on enhancing motivation to change and abstain from substances, substance use problem acknowledgement, and recognition of the need for external support may promote attendance (Cloud et al., 2006; Laudet, 2003; White & Kurtz, 2006). In one study with adults admitted to an alcohol detoxification program, a 12-step motivational enhancement condition did not increase attendance at 12-step groups or improve drinking outcomes; however, the motivational approach was found to be more effective with individuals with little prior 12-step group experience (Kahler et al., 2004).

None of the above linkage strategies have been empirically tested with youths. Research in this area is needed to identify the most effective and appropriate referral strategies for young people. Motivational enhancement techniques may be especially appropriate for this population because of their tendency to have low substance use problem recognition and to have less experience with recovery support groups (Kelly, Myers, Rodolico, in press). One study has provided preliminary information about the relationship between referral strategies of adolescent substance abuse treatment providers' and rates of self-help meeting attendance. Analyses of interviews with clinicians from eight sites across the United States revealed that staff located at sites with the highest overall rates of adolescent self-help meeting attendance tended to engage in certain activities that the other sites did not or did to a lesser extent. They actively linked youths to the recovery community in the following ways: 1) by bringing them to sober social activities sponsored by support groups (e.g., young peoples' conferences and sober dances, picnics, and retreats); 2) by working with service structures of support groups to host meetings and to locate good role models for youths; 3) by forming formal and informal networks of trusted people to accompany youths to meetings and/or to introduce them to the group; 4) by monitoring recovery support group attendance post-discharge through continuing care or case management; and 5) by helping youths identify and approach potential sponsors and then by interacting with and screening them for appropriateness. Appropriate sponsors possessed a good understanding of the 12-steps, worked the steps themselves, and had their own sponsor (Passetti & Godley, 2007).

Given these findings, professionals attempting to enhance youth attendance at recovery support groups may want to research support group-sponsored activities in youths' communities and assemble a list of *reliable*, diverse individuals that can serve as temporary guides to a particular support group (Forman, 2002; Johnson & Chappel, 1994; White & Kurtz, 2006). Group members that have experience with or are willing to work with young people and are knowledgeable about local meetings may be identified through the committees of various support groups, consultation with colleagues, prior experience with youths who are connected into the recovering community, or communication with staff at substance abuse treatment facilities. Ongoing monitoring of youths' interactions with group members, especially sponsors, and of their experiences at meetings may assist professionals in assessing the relationships that are formed as well as reactions and obstacles to participation.

Conclusion

Further investigation is clearly needed into the effectiveness of youth involvement in recovery support groups and into the usefulness of various referral strategies. Referrals to such groups are a promising avenue for future investigation. In order to assist young people in this area, professionals may want to engage in the following activities: 1) research the characteristics of local meetings, including age composition of members, so that referrals can be tailored based on youths' needs, preferences, and cultural backgrounds; 2) help young people structure their time before and after meetings and with group members to minimize situations that may lead to relapse; 3) become familiar with

group customs and languages in order to prepare youths for meetings, make appropriate referrals, and clear any misunderstandings; 4) investigate the variety of recovery support groups offered in a given area to provide youths with a menu of options; 5) recognize that some youths may need to try a diversity of meetings before finding one (or a combination of more than one) that feels comfortable; 6) interact with recovery support group service structures and develop a list of reliable group members to connect youths to the recovering community; and 7) implement assertive rather than passive referral strategies, including monitoring of reactions to experiences and program concepts.

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Citation: White, W., Schwartz, J. & the Philadelphia Clinical Supervision Workgroup (2007). The Role of Clinical Supervision in Recovery-oriented Systems of Behavioral Healthcare. Philadelphia: Department of Behavioral Health and Mental Retardation Services. Posted at **www.williamwhitepapers.com**

The Role of Clinical Supervision in Recovery-oriented Systems of Behavioral Healthcare Monograph Series January 2007

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[1] The Philadelphia Clinical Supervision Workgroup was appointed by the Philadelphia Department of Behavioral Health and Mental Retardation Services staff to collaborate in creating a vision of clinical supervision within the behavioral health systems transformation process that is underway in Philadelphia. This first paper focuses specifically on clinical supervision in addiction treatment settings and the Workgroup includes clinical supervisors representing different modalities and levels of care of addiction treatment.

Introduction

Converging paradigmatic shifts are underway in the field of addiction treatment and the broader arena of behavioral health care. First, there is a shift in emphasis from pathology to the pathways and processes of long-term recovery (White, 2004b, 2005). Second, there is the complimentary call for the redesign of addiction treatment from a model of acute care (biopsychosocial stabilization) to a model of sustained recovery management (recovery consolidation, monitoring and maintenance). This latter shift is evident in calls for models of chronic disease management (O'Brien & McLellan, 1996; McLellan, et al, 2000; Watkins, et al, 2003), extending case monitoring (Stout, et al, 1999), recovery management (White, Boyle & Loveland 1998, 2002; Dennis, Scott & Funk, 2003; White, Kurtz & Sanders, 2006), concurrent recovery monitoring (McLellan, et al, 2005), assertive continuing care (Godley, Godley & Dennis, 2001), adaptive treatment protocols (McKay, 2005), and a resiliency, wellness and recovery model (Flaherty, 2006). Viewed collectively, these reflect efforts to transform addiction treatment into a "recovery-oriented system of care."

The paradigm shifts being advocated involve dramatic changes in addiction treatment services philosophies, service technologies, service roles and relationships, and the relationship between service organizations and other community recovery support resources. There is little within the existing system of addiction treatment that will not be challenged in the coming decades as new service roles (recovery coaches, recovery support specialist, personal recovery assistants) and recovery support organizations (community recovery support centers) emerge and stand-alone levels of care become obsolete within the transformed world of addiction treatment (White, 2005, 2006; Compton, Glantz & Delaney, 2003).

These changes will exert a profound influence on the importance and design of clinical supervision in addiction treatment organizations. The goals of this article are to:

1. define recovery-focused supervision
2. identify the core principles upon which this style of supervision is grounded
3. describe changes in the structure and process of clinical supervision that occur within recovery-oriented systems of care, and
4. explore how recovery-focused supervision changes staff relationships with their clients and the community.

This paper integrates national and local perspectives. The lead author (White) has, in his role as recovery historian, advocate and researcher, aggressively promoted the shift toward more recovery-oriented systems of care, and has consulted with federal, state and local agencies to facilitate technical aspects of this transformation. The second author (Schwartz) has, in his role as the Clinical Director of Dawn Farm, been at the forefront of implementing this paradigmatic shift within a long-standing, community-based treatment organization in Ann Arbor, Michigan. The members of the Philadelphia Clinical Supervision Workgroup (PCSW) are clinical directors and supervisors from addiction treatment programs located in the Philadelphia metropolitan area appointed by the Department of Behavioral Health and Mental Retardation Services to explore the role of clinical supervision in creating a more recovery-focused behavioral health care system in the City of Philadelphia. Workgroup members represent multiple levels of care including therapeutic communities and methadone maintenance programs and adult and adolescent treatment programs. The experiences of Dawn Farm, selected Philadelphia-area treatment programs and other recovery management pilot sites will be used as learning laboratories from which we will illustrate key points in this paper. Toward that end, we will briefly profile Dawn Farm, and the behavioral health "system transformation" that is underway in Philadelphia.

Dawn Farm is a therapeutic community in Ann Arbor, Michigan founded by two recovering addicts in 1973. Although the founders had strong ties to the recovering community and the larger community, Dawn Farm became progressively isolated and developed increasingly hierarchical relationships with its clients. Over a span of two decades, Dawn Farm became:

- pathology-focused (delving deeply into an ever-ending list of client problems)
- preoccupied with power and control (via preoccupation with rule enforcement and power struggles that resulted in high rates of premature self-discharge and disciplinary discharge),
- family aversive (assuming based on years of experience with very toxic families that all clients needed to be protected from their families), and
- arrogant, condescending and aloof (e.g., shaming returning clients for relapsing, conveying to the recovery community that treatment was more important than peer-based recovery support, undermining the service roles within the recovering community by absorbing sponsorship functions).

One of the earliest turning points in this history involved Dawn Farm's experiment with transitional housing in the late 1990s. Sober housing was provided without any treatment, but with the expectation that residents would work full-time, pay rent, live within basic house rules and attend recovery mutual aid meetings on a daily basis. It became evident over time that many transitional housing clients were achieving a more solid and sustainable recovery than people who were receiving long-term residential treatment at Dawn Farm. This led to Dawn Farm undertaking a "fearless and searching" inventory of its philosophies and clinical practices. The result was a refocused mission, a new treatment philosophy and significant changes to clinical practices and clinical supervision, and a radical reconstruction of Dawn Farm's relationships with its service consumers, with the recovery community and with other helping organizations.

In 2004, Dr. Arthur Evans was appointed the first director of the newly created Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS). Following extensive dialogue with community stakeholders, a decision was made to embark on a sustained process of "systems transformation" that would reshape DBH/MRS into a system that was recovery-oriented, client/family-driven, holistic, culturally competent, trauma-informed and evidence-based. DBH/MRS created a Recovery Advisory Committee and entered into partnership with its treatment providers, local recovery advocacy organizations and the faith community to reshape behavioral health services. Those partnerships are fundamentally redefining the conceptual premises, management practices and service technologies for DBH/MRS and local behavioral health care providers in Philadelphia. This system transformation process has been detailed in two recently published documents: *Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change* (2006) and *An Integrated Model of Recovery-Oriented Behavioral Health Care* (2006). In the spring of 2006, DBH/MRS established a clinical supervision work group to explore changes in clinical supervision that will need to occur as part of the systems transformation processes in Philadelphia. The highlights of workgroup discussions are reflected throughout this paper.

Defining Recovery-focused Clinical Supervision

Clinical supervision as we once knew it is now almost non-existent.
--Long-tenured Clinical Director

The supervision of frontline addiction service professionals (counselors and other direct service staff) has historically involved two quite different functions: clinical supervision and

administrative supervision. Lindbloom, Eyck and Gallon (2003) distinguish these functions as follows:

> *Clinical supervision emphasizes improving the counseling skills and effectiveness of the supervisee. Administrative supervision emphasizes conformity with administrative and procedural aspects of the agency's work.* (p. 22).

Considerable tension exists between the demands emanating from these two spheres of supervisory activity. A single person usually performs both of these functions, and demands in both of these areas have increased exponentially in recent decades (Dixon, 2004). As a result, front line clinicians and supervisors alike report that clinical supervision has been hijacked by financial (e.g., negotiating with managed care gatekeepers), regulatory (e.g., keeping up with documentation), and administrative (e.g., attending meetings) demands (Durham, 2003). These escalating demands on treatment programs are a product of redundant accountabilities to federal, state, county, city and private regulatory bodies that produce an exponential growth in standards and monitoring site visits. Clinical directors and supervisors report that pockets of high quality clinical supervision continue to flourish, but that they now represent the exception. There is no consistent structure of clinical supervision within the field or even across programs within the same treatment organization. Other factors that have compromised the quality of clinical supervision include concurrent demands for supervisors to carry clinical caseloads and the demands to perform clinical duties when counselors are absent for vacation, illness, medical leave, training, or resignation. Retaining and developing staff is particularly challenging in such historically stigmatized treatment modalities as methadone maintenance clinics.

In the wake of such demands, supervisors and clinicians report feeling like they have become people and paper processors and that it is getting harder to feel good about what they are doing in their professional lives. They express fears that even the collective memory of client-focused care and quality supervision will be lost as this generation of long-tenured supervisors and clinicians ages out of the field. What we will describe here as recovery-focused clinical supervision is not possible without providing clinical supervisors relief from these administrative demands and renewing the focus on service relationships and service outcomes in addiction treatment.

As a field, we are calling for services that are developmentally appropriate, gender specific, family centered, culturally competent, trauma-informed, strengths-based and evidence-based (to name just a few). The call for recovery-focused clinical supervision could be experienced as one more faddish demand placed upon already over-burdened service roles, or a framework for integrating many of these recent initiatives and a means of recapturing the importance and integrity of clinical supervision within addiction treatment. It is our hope that it will be the latter.

> ***Recovery-focused clinical supervision*** *(RFCS) is the process through which a clinical supervisor assures that services to AOD-impacted individuals, families and communities are directed toward their ultimate goals: the permanent resolution of AOD problems and the enhancement of global health and functioning. The mechanisms through which these goals are achieved include program development; staff recruitment, orientation and training (knowledge, skills and attitudes); modeling core recovery values; case consultation; fidelity monitoring; performance evaluation; liaison with community recovery support resources; and program evaluation and policy advocacy.*

Success in RFCS is measured by the degree to which the service activities of supervisees result in intermediate and long-term recovery outcomes for the individual, family and community. Short-term outcomes for the individual and family include such elements as early identification,

engagement, biopsychosocial stabilization, recovery initiation, and assertive linkage to communities of recovery. Long-term outcomes are focused on two non-negotiable goals: 1) the sustained reduction and resolution of AOD problems and 2) enhancement of each client and family's global health and functioning. Global (whole) health is measured along such dimensions as physical health, emotional health, the stability and quality of family and peer relationships, the safety and comfort of one's living environment, positive community participation, and life meaning and purpose. In short, global health embraces the whole person/family, including the causes and effects of illness. Short-term outcomes for the community include relationship building between the treatment institution and indigenous communities of recovery, identification of existing recovery support resources, and recovery resource needs assessment. Long-term outcomes include recovery community mobilization, expansion of local recovery support resources, reductions in social stigma attached to recovery and the expansion of the physical, psychological and social space where recovery can flourish.

The focus of RFCS is on building recovery capital[2] in the individual, family and community. Recovery capital constitutes the internal and external assets that one can draw upon to initiate and sustain recovery and achieve a meaningful life in the community (Granfield and Cloud, 1999). RFCS 1) directs attention beyond the achievement of professionally-guided acute biopyschological stabilization toward the processes of client-directed recovery consolidation and sustained recovery self-management, 2) extends the focus of services beyond the individual to the family and social network and larger cultural community, and 3) integrates clinical models of intervention with models of cultural renewal and community organization/development. RFCS is an attempt to respond to what we believe are justifiable criticisms, that addiction treatment has become disconnected from the larger and more enduring process of addiction recovery, and that addiction treatment institutions have become disconnected from the grassroots communities (and local communities of recovery) out of which they were born (White, 2001; White & Hagen, 2005).

Foundational Recovery Principles: Implications for Clinical Supervision

Recovery-focused clinical supervision (RFCS) is grounded in a number of core principles about the nature of recovery from severe AOD problems and the role of professionally-directed treatment in that resolution process.[3]

There are multiple pathways through which AOD problems can be resolved. These pathways span diverse:

- religious, spiritual and secular frameworks of recovery and their corresponding mutual support structures
- catalytic metaphors (key words and ideas that spark recovery initiation)
- degrees of recovery (partial, full, transcendent)
- methods of recovery initiation and maintenance (abstinence-based, moderation-based, medication-assisted; solo, peer-assisted, professional-assisted)
- differing relational styles of interacting with other people in recovery (acultural, bicultural, and enmeshed), and
- varying identity adaptations to the recovery experience (recovery positive identity, recovery neutral identity, recovery negative identity) (See White & Kurtz, in press for a review).

[2] Recovery capital is the total internal and external assets that an individual can mobilize to initiate and sustain recovery (Granfield & Cloud, 1999).

[3] For an elaboration of the recovery-related research upon which these principles are based see White & Kurtz, 2006.

This principle calls for the extension of the counselor and clinical supervisor's expertise from a focus on addiction and treatment processes to an in-depth understanding of long-term recovery processes. One of the most significant implications of this understanding is the need for the clinical supervisor to enhance each counselor's understanding of recovery pathways and to utilize this knowledge within highly individualized service planning and delivery processes.

Pathways and styles of AOD problem resolution are greatly influenced by the interaction of problem severity and recovery capital. The need for professionally-directed treatment and sustained recovery supports rises in tandem with increasing problem severity/complexity/chronicity and decreasing recovery capital. Persons with lower problem severity and higher recovery capital may resolve AOD problems without formal peer/professional assistance or with brief models of such assistance, and are often utilize moderation-based approaches to problem resolution. Individuals with high personal vulnerability, high problem severity and complexity, and low recovery capital (the dominant profile of people entering addiction treatment in the United States) often require abstinence-based models of treatment and systems of sustained peer-professional recovery support. This principle calls for a thorough assessment of recovery capital, level of care placement decisions that factor the interaction of problem severity and recovery capital, and a potential shift in focus from decreasing pathology to increasing recovery capital. RFCS helps staff keep their eyes on the prize. The ultimate goal is not treatment: it is sustainable recovery.

Pathways and styles of recovery differ significantly across developmental experience, primary drug, developmental age of recovery initiation, gender, culture and degree of cultural affiliation and the presence and severity of co-occurring problems. Individuals often combine words, ideas and rituals from multiple sources to construct a personally and culturally congruent style of recovery. This principle provides the framework to integrate other initiatives within RFCS (e.g., cultural competence, gender-based treatment), while focusing these efforts specifically on those service adaptations that have significance for recovery outcomes.

Acute biopsychological stabilization in and of itself is not a predictor of recovery outcome; serial episodes of such stabilization are as likely to be milestones in one's addiction career as milestones of recovery initiation. RFCS helps service workers transcend the demands of detoxification and chaos management posed by each client to find windows of opportunity for entry into sustainable recovery. RFCS helps staff define their roles within recovery processes (and sometimes multiple treatment processes) that span years, as an alternative to a narrow focus on a prescribed set of activities that must be completed in a set number of days or sessions.

Short-term behavioral compliance with treatment protocol is enhanced by external coercion; long–term recovery outcome is enhanced by choice and commitment. Treatment can be coerced, but sustainable recovery is by definition a voluntary process. Supervisees inevitably drift toward a focus on pathology and preoccupations with coercion and control (particularly during periods they are experiencing high stress and diminished support or during periods of rapid turnover of clients). One of the key functions of the recovery-focused supervisor is to continually help supervisees re-shift their focus from pathology to strengths, control to support, frustration and anger to re-engagement and encouragement. Recovery involves a rehabilitation of the will; client choice and feelings of personal self-efficacy enhance the strength, durability and quality if life in recovery.

Long-term recovery outcomes can be enhanced by unique combinations and sequences of services that generate synergistic or cumulative effects on recovery initiation and maintenance Anglin, Hser, & Grella, 1997; Dennis, Scott, Funk & Foss, 2005). All approaches to addiction treatment and all recovery support frameworks have persons who fully respond, partially respond or do not respond to their respective approaches (Morgenstern, Kahler, Frey & Labouvie, 1996). This principle suggests the need for clinicians to look beyond their particular type of service or level of care toward constructing potent, personally matched service combinations and sequences. This requires seeing treatment episodes not as discrete events

that succeed or do not succeed, but as steps in the search for a match between person and recovery priming ingredients.

All recovery-focused services hinge on effective engagement: The service RELATIONSHIP is the foundation of recovery-oriented systems of care and all clinical and non-clinical recovery support services. Everything we are able to help each client achieve is contingent upon sustaining an empathic relationship. Recovery-focused treatment is about engagement, engagement, engagement. The process of engaging and motivating each client is a continual one, as the strength of our service relationships and each client's motivation for recovery ebbs and flows. At a practical level that means that every contact with a client is about re-engagement and re-motivation. Our degree of effectiveness with this task is measured at the most basic level by our ability to enhance service retention rates, lower rates client-initiated disengagement from services and lower rates of administrative discharge (see White, Scott, Dennis & Boyle, 2005).

Community is the ultimate healing agent, not treatment. Where communities have been so wounded that they lack such healing powers, efforts must be undertaken to find, awaken and help actualize the hidden resiliencies within those communities. Some think of this as treating the soil in which addiction flourishes (Coyhis, 1999). The primary role of treatment is to remove the personal and environmental obstacles that prevent this connection to a recovery-supportive community and to participate in building such communities where they do not yet exist.

The greater the physical, psychological and cultural distance between the treatment center and each client's community, the greater the problem of transferring learning from the institutional to the natural environment. Recovery is not viable until it has been anchored within the life of the community. At its most practical level, this requires knowledge (on the part of the counselor and the supervisor) of each client's recovery environment, linkage to supports within the client's natural environment and continued monitoring and support of each client within his or her natural environment. It could also involve working with the client to develop a more recovery-conducive environment.

Practice Changes in Recovery-Focused Clinical Supervision

In this section we will provide an overview of the changes in clinical supervision necessitated by the shift from an acute care (AC) model of addiction treatment to a sustained model of recovery management (RM). Those changes will focus on twelve dimensions: client engagement and motivation, screening and assessment, service planning and coordination, service goals and focus, service relationship, role of the client, service team, counseling and treatment, locus of services, duration of services, discharge and "aftercare" services; advocacy and recovery community development (White, Boyle & Loveland, 2002).

Client Engagement and Motivation

RM models emphasize the importance of early engagement via community screening and assertive approaches to outreach and sustained motivational enhancement. These strategies are based on several assumptions.

- *Early intervention into chronic diseases can shorten the duration and intensity of the disorder*; the earlier the age and stage at which treatment begins, the shorter the addiction and treatment careers and the longer the recovery career (Dennis, Scott, Funk & Foss, 2005).
- *Neurological impairments compromise choice-making abilities during active addiction and early recovery, increasing relapse risks*. This hijacked reward system, which imposes a higher value on compulsive drug use than on other human needs and values, continues into the early stages of recovery and raises the risk of treatment disengagement and resumption of AOD use. The health of

this reward system can be buttressed by pharmacological adjuncts, professional counseling and recovery peer support until such time as the client's capacities for healthy choice-making are restored or developed (Dackis & O'Brien, 2005; Shaman & Hope, 2005).

- *The primary responsibility for initiating motivation for recovery and sustaining that motivation during the earliest stages of recovery lies with the treatment staff, not the client*. RM models emphasize the existence of developmental windows of opportunity for change ("teachable moments"), priming motivation for recovery where none exists, and the catalytic power of mobilizing recovery capital within the client's family/social network.
- *Hope is the key*. Recovery initiation is often a synergy of pain and hope, but experienced or threatened pain in the absence of hope cannot sustain recovery initiation. RM models emphasize the importance of hope in the recovery process via empathy, rapport, encouragement and exposure of each client to recovery role models with whom he or she can identify.
- *Client motivation, like staff motivation, ebbs and flows and must be actively managed*. Both must be actively managed through the process of clinical supervision.
- *Transformational change (recovery that is unplanned, sudden, positive and permanent) is possible among clients with even the poorest prognoses.* Bill Wilson (co-founder of AA) and Mrs. Marty Mann (Founder of the National Council on Alcoholism and Drug Dependence) had ten prior treatments between them before each underwent a profound breakthrough experience during treatment that launched their successful recoveries and their historical contributions that have touched millions of lives (White, 2004c).
- *Engagement strategies must be refined for historically marginalized populations*. Outreach workers (cultural guides) nestled within natural environments and using non-traditional approaches can facilitate identification, screening and service linkage and retention (White and Sanders, 2006)

These understandings have several implications for clinical supervision. At a programmatic level, attention is given to relationship building with early identifiers: families, clergy, physicians, indigenous caretakers, and other helping professionals. Where formal and assertive approaches to outreach are used, several issues are critical in supervision, from the safety of outreach workers to processing such questions as, "When does "no" really mean "no"!? When do you give up for the time being? When should we check back with someone who cannot be engaged at this moment? A crucial question is: What sustains the motivation of the outreach worker to maintain contact with the prospective client during pre-action stages of change? The answer is the encouragement and support of the supervisor, who must serve as a cheerleader in this difficult, early engagement process. The ability of the supervisor to empathize with his or her supervises and their emotional reactions to difficult-to-engage clients is the foundation upon which effective outreach is built and sustained.

Once initial contact with clinical staff is possible, great emphasis is placed in the engagement process (empathy, rapport), relationship building skills, and strategies for identifying and managing mutually self-defeating styles of interaction between counselors and clients. Key supervisory strategies to facilitate this is to establish clear expectations for the values that guide staff interactions with clients (courtesy, respect, helpfulness, friendliness) and immediately confront behaviors that convey disregard and disrespect. Training in stages of change models, motivational enhancement therapies & strengths-based counseling and incorporating principles from these approaches within clinical supervision sessions are highly recommended. Clinical supervision in recovery-focused systems of care shifts the focus from

the diagnosis of pathology to identifying and enhancing each client's internal and external recovery capital. Training related to transformational change can help staff recognize such experiences and prevent them from intervening in ways that could abort what could otherwise be a life-changing breakthrough.

Supervisors can also use the phenomenon of parallel process by modeling the core values and behaviors they wish to see within client service relationships in their own relationships with supervisees. This focus on engagement and relationship maintenance also means greater explorations of transference and counter-transference issues during clinical supervision sessions.

In recovery-oriented systems of care, the focus in supervision of the engagement process shifts from the mechanics of the intake process to the development of a strong service relationship and working through obstacles in the engagement process. Some programs find this engagement process is enhanced by:

- Providing pre-treatment recovery support services to enhance treatment readiness and reduce attrition from service waiting lists.
- Shifting from an addictions model to an alcohol and drug problems model (as defined and understood by each client)
- Lowering the threshold of initial service engagement by truly meeting client "where they are at".
- Exploring strategies in supervision to enhance each client's investment in the treatment experience.
- Using peer supports as a way to offer hope for long-term recovery. Facilities that have treated physicians have effectively used physicians in recovery as peer coaches for years as a routine component of physician health programs (formerly known as impaired physician programs).
- Using clinical supervision as a pre-condition for administrative discharge and as a process to explore alternatives to AD (see White, Scott, Dennis& Boyle, 2005)
- Developing attitude protocol related to returning clients that conveys messages of regard, welcome, optimism and respect.
- Using community resources as sources of motivational enhancement
- Using frameworks of meaning to help clients understand that obstacles, struggles, and relapses are all building blocks in the client's recovery process.
- Sustaining the hope of staff by keeping them in touch with former clients in long-term recovery and with the larger recovery community.

Effectiveness in this area can be measured by a number of indicators: 1) increased percentage of clients entering treatment who are not under external coercion, 2) increased percentage of clients who follow through after an initial assessment and service plan, 3) decreased percentages of clients who leave against staff advice or are administratively discharged, and the percent of clients discharged unsuccessfully who maintain engagement in another level of care or later reengage in the same level of care..

In the late 1980s, the State of Illinois developed an innovative project to engage addicted women with histories of abuse or neglect of their children. One of the hallmarks of Project SAFE was an extremely assertive model of outreach that brought an unprecedented number of women into treatment. When the outreach workers within this project were asked to describe how they successfully engaged these clients, they responded as follows:

Dimensions of Assertive Outreach and Engagement
(Excerpted from White, Woll & Godley, 1996).

Expect Resistance *Resistance is to be expected; we should be shocked when it's not there and suspicious that we're getting hustled. These women initially see us as an extension of the Agency that's taking their children and forcing them to get help they don't need or want. It takes time to work through their anger and distrust.*

Demonstrate Respect *I try to remember that I'm on her turf--that I'm her guest and that I remain there only with her permission. I want to minimize my power and let her feel we=re on the same level. I try to empathize with her sense of being invaded--her feeling that all these strangers are getting in her business.*

Listen *They can't hear you until you've heard them. The trick is to shut up and listen until they're ready to hear what you have to offer. I think it's the first time they've been listened to and not judged.*

Tell Your Story *I wait for the right time and then I share my story and my gratitude about what happened to me as a result of treatment. When she figures out I been where she's at, something just seems to click. It's like they want something I got and for the first time figured out it might be possible to get it. We're from the neighborhoods. We've lived in ...public housing sites. You go to the same stores that they do. You already know what they're going through. It's not like they have to hide anything.*

Empower *Its harder for the women I see in the projects because they don't see a lot of people making it. I hope she can identify with me in a way that opens up her sense of possibilities and choices.*

Affirm *I tell her something good about herself--something I see that others may have missed. I just keep listening and telling her everything's possible until she asks me "how?" Then I tell her that her beauty's being wasted and what she can do for herself and her family. I also keep leaving those "You can do it!" notes on their doors.*

Accept *You can't be judgmental. You have to be willing to allow the clients to make mistakes and to be resistant, because that's what they are. When you do outreaching, one thing you need to do is be an equal. You have to let the client know that you're no better, that you're her equal.*

Be Tenacious *You've got to let them get all their anger out before they can hear anything you've got to say. When they're done cussing, I start talking.* [I say through a closed door:] *I know you're there. I know you're mad. But I ain't gonna give up on you. I'll be back tomorrow. I hope you have a good day.At first she didn't want to talk to me, but I just kept showing up at all her court hearings. They just surrender. They finally realize that we're not going to let off. That we'll keep at it until we give them the help they desperately need. They have to know you care enough that you won't give up.*

Problem Solve *My job every day is to resolve anything that threatens to keep this woman from getting to treatment.*

Be Real *Who am I? I'm somebody who can show you how to get those people off your ass!*

The following Philadelphia case study illustrates what might be called *institutional outreach*—an intense process of engaging an individual through hourly/daily contacts at the earliest stage of treatment.

> *Charlotte was a 45 year-old crack-addicted female with a serious medical condition, Bipolar Disorder, and an extensive history of sexual abuse both as a child and adult. Charlotte, after much encouragement and direction, completed short-term stabilization unit and transferred to a long-term residential facility. Her first 2 weeks of treatment were difficult and she was extremely withdrawn and uncooperative. When she did speak, she made it clear that she did not believe in the Therapeutic Community. Two female staff met with Charlotte almost on a daily basis, just to talk and build a relationship with her. As the days went on Charlotte opened up more and more and slowly became part of the community she had criticized. She successfully completed treatment 7 months later, followed that with 4 months of outpatient treatment while residing in transitional housing and then moved into her own apartment. Today, she is physically stable, continues to attend mental health therapy monthly, has a full-time job and visits the treatment facility regularly to speak with the current residents and share her story of accomplishment while encouraging them to remain in treatment in order to live a more productive sober life.*

Successful engagement and retention can be enormously challenging and clients can present with chronic self-defeating styles of interacting with others that sets them up to split or get thrown out of treatment. Penetrating these styles can be difficult but rewarding as the following incident reveal.

> Welcoming the Return of a "Problem Client" *Nancy was a 23 year old heroin addicted female from an affluent suburban family. Her clinical history included childhood sexual abuse, multiple rapes as an adult, a severe eating disorder and recent psychiatric diagnoses of bi-polar disorder and schizophrenia. These problems had spawned five admissions to residential treatment—each of which resulted in discharge following vicious verbal abuse of other clients. When she asked to come back for a 6th time, the initial staff reaction was that she would simply be too disruptive to the treatment milieu to consider her admission. As we processed this more, we were forced to acknowledge that, as badly as she acted out in treatment, she was doing much better than when we first met her – something was working. We met with the client and asked what she thought would help move her recovery forward and we shared our thoughts with her. Together, we developed a workable plan that included transitional housing, volunteering at the homeless shelter and at detox, attending daily groups at the residential treatment site and participating in outside individual counseling.*

Screening and Assessment

In shifting from acute care models to models of sustained recovery management, assessment processes and instruments shift from assessments that are categorical, deficit-based, individual-focused and an intake function to assessments that are global (wholistic), strengths-based, continual and family-centered. Achieving this shift requires swimming upstream against the currents of existing regulatory and service reimbursement schemes. Clinical supervisors who are so inclined will play a significant leadership role in advocating for changes in these structures as well as making changes in their own institution's assessment protocol. This often involves upgrading to global assessment instruments (e.g., Substance Abuse Severity Index, Global Appraisal of Individual Needs), further refining or supplementing these instruments for cultural applicability and implementing strengths-based assessment and

service planning procedures. The key is an assessment process that provides a complete picture of the health of each client across multiple zones of functioning, e.g., chemical/physical, cognitive/emotional, relational (intimate/family/extended family/social/cultural), ontological (spirituality, life meaning and purpose), and lifestyle (safety/security, school/work, leisure, legal, financial) health.

Traditional assessment, diagnostic and patient placement criteria have been driven primarily by the measurement of problem severity. The largest change in RM models is the inclusion of recovery capital as a major factor in the assessment and service planning process. Consider the following three examples.

1) High problem severity, which would usually dictate a more intense and restrictive level of care, could be offset by a high level of recovery capital that would allow the client to be successfully treated in a lower level of care.
2) Low to moderate problem severity combined with exceptionally high recovery capital might indicate a very low level of professional intervention (e.g., brief therapy) or a monitored attempt to initiate and sustain recovery without formal professional intervention, e.g., monitoring and recovery coaching without clinical services. This combination would also reflect individuals who may not need sustained recovery management or who would only need minimal recovery support, e.g., an annual recovery checkup.
3) High problem severity and complexity (co-occurring disorders, multiple prior treatments) combined with low recovery capital would signal the need for long-term recovery management and a high level and intensity of services required for recovery initiation, consolidation and maintenance.

Where traditional supervision has focused on the identification or elimination of pathology, clinical supervision in the RM model shifts the emphasis to the identification and enhancement of recovery capital. Without systemic changes to support this shift, there is a danger we will identify a greater range of needs and potentialities only to then demoralize the client/family as we confront the limited community resources to help fulfill those potentialities.

Care will need to be taken in supervision to reconcile this broader identification of client needs with local resource limitations. The advantage in the RM model is that service priority sequencing can unfold over a much longer span of time that with AC models of care. Thus, all of those needs do not need to be addressed in a matter of a few sessions or weeks.

Another assessment dimension that changes within RM models is the shift from the individual to the family as the unit of assessment and intervention. Again, this requires moving against mainstream regulatory standards and reimbursement procedures that focus almost exclusively on service to individuals. The challenge for the clinical supervisor is to create family systems of care within the limitations imposed by these external systems (until such time as advocacy can elicit changes in those systems). This increased family focus is based on the understanding that severe AOD problems tend to cluster and move intergenerationally within particular families at the same time recovery support resources exist within nearly all families, extended families and kinship networks. It is also based on the understanding that chronic disorders tax the adaptational capacities of families and disrupt the health of individuals, intimate relationships, parent-child relationships, sibling relationships and alter the nature and frequency of the family's interactions with those outside the family. Assessing and supporting the family as a whole through the process of clinical supervision can minimize family sabotage, mobilize family support for recovery, reach other family members at an earlier stage of problem development, enhance the health of family members and the family system as a whole and potentially break intergenerational patterns of problem transmission.

Service Planning

In traditional service planning within addiction treatment organizations, assessment data is used to generate a problems list that is then used to formulate a professionally-directed treatment plan. The treatment plan is usually prepared by an addictions counselor and is often approved via the signature of the medical director. In the RM model, a treatment plan may still be indicated for the earliest period of biopsychosocial stabilization, but the treatment plan rapidly gives way to the development of a client-formulated and client-directed recovery plan. The recovery plan is broader in scope than a traditional treatment plan, encompassing such domains as physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality. It usually consists of a master plan that identifies long-term recovery goals and a weekly action plan of steps that will be taken to move toward those goals (Borkman, 1997). Advocacy with funding and regulatory authorities is usually required to shift service planning protocol as well as the forms that constitute the medical record.

Clinical supervision is important to help staff: 1) divest themselves of the power inherent in the expert role and to move toward the role of recovery consultant, 2) develop approaches to motivating clients for ownership of recovery planning (particularly those re-entering treatment), and 3) clarifying client and counselor or recovery coach role responsibilities. Staff members are evaluated on their ability to engage clients in recognizing and identifying strengths and competencies within the recovery planning process. Dr. David Loveland, recovery coach supervisor, at Fayette Companies in Peoria, Illinois, describes the difference between traditional treatment planning and recovery planning.

> *Treatment planning is based on a medical model that focuses on deficit (a diagnosis) and professional interventions designed to cure or stabilize symptoms of disease. In contrast, recovery planning is based on the life goals and aspirations of each individual; deficits are a focus only to the extent they constitute barriers to these goals and the long-term recovery process. Recovery plans are generated, implemented, evaluated and refined by each client with the counselor or recovery coach serving as consultant and cheerleader. The supervision of successful recovery planning first helps staff move from hierarchical to collaborative service relationships and then cultivates the courage to allow clients to make and learn from their mistakes without threat that their decisions will be shamed or punished. The key is to avoid the intellectual debates and power struggles—to cease indoctrinating, manipulating and controlling. Staff members need guidance to replace traditional, paternalistic and materialistic interventions with more focused support and consultation roles—roles through which we plant the seeds for helping each client evaluate short- and long-term recovery pathways and strategies. We do that, not by convincing a client that he or she is making a bad choice, but by forging a recovery support partnership and asking such questions as: How will we know if this approach is working for you? What are the early signs that will tell us this approach is not working? What ground rules will assure the best probable outcome? Such questions, whether applied to a cocaine addict who wants to try controlled drinking or a client who wants to go to a wedding with an open bar, help clients develop critical thinking skills that can guide the process of long-term recovery.*

Service Goals and Focus

Treatment sites that are attempted to move to a recovery management model continue to do acute stabilization when this is needed but they wrap these acute services within a larger system of support for long-term recovery.

We used to see our work as being completed at the point someone was discharged from primary treatment. Now we see this as the beginning of our work supporting the transition from recovery initiation to recovery maintenance.

Some programs report that their treatment philosophies undergo significant changes in this transition. Such changes may include the following:

1) Abstinence may be viewed as a method or strategy rather than as the goal; the goal is recovery—abstinence is one method, and, for those with severe AOD problems, the preferred method of achieving that goal.
2) Moderation goals and outcomes may be considered for those with less severe AOD problems.
3) Recovery is viewed across a much longer time perspective, with an understanding that, for those clients with the greatest problem severity and complexity, stable abstinence may come slowly and following multiple service interventions.
4) Recovery management can also involve an integration of treatment and harm reduction approaches (Kellogg, 2003; Schwartz & Balmer, 2003).

These shifts in philosophies are based on the understanding that different clients may utilize different goals and strategies of problem resolution and that the same person may embrace different goals and strategies at different points in their life. The focus that emerges from that shift in thinking is the development of a recovery-supportive relationship that can support recovery initiation and stabilization and then support the transition to long-term recovery self-maintenance. Clinical supervisors are playing a critical role in refocusing treatment from biopsychosocial stabilization to long-term recovery. They are supporting this shift by involving staff in discussions of clinical research and its implications for treatment philosophy, by introducing new service technologies and by moving staff away from a focus on control and compliance toward a focus on relationship-building and recovery support. In short, the job of the clinical supervisor is to hold recovery up as the prize that we must keep our eyes upon and use that singular goal to determine service priorities. Where recovery is likely to be a complicated, obstacle-filled process, the supervisor can help staff stay engaged by staged recovery outcomes and emphasize the potential importance of service combinations and sequences.

Service Relationships

One of the most dramatic changes in recovery-oriented systems of care is the radical reconceptualization of the role of service provider and service recipient and the nature, intensity and duration of the service relationship. Modern addiction counseling has adopted a psychotherapy model of intervention drawn from the fields of psychiatry, psychology and social work. In this model, the addiction counselor serves as a professional expert who performs such key clinical functions as screening, assessment, treatment plan preparation, client/family education, client/family counseling, discharge planning and possibly brief follow-up after discharge. There is considerable power discrepancy in the service relationship and the treatment process is directed by the addictions counselor over a relatively brief period of time. In this system of care, the client may go through multiple levels of care providing by different agencies and different service professionals.

In recovery-focused systems of care, the service relationship is less hierarchical and the role of the service professional might be more aptly described as a consultant and mentor than that of a therapist. The service relationship is less like a traditional doctor-patient relationship and more like a sustained health care partnership, with the client rather than the service provider in the central decision-making role. This means that service relationships are focused less on

the therapist and more on the client and extend much longer in time than traditional treatment relationships.

In shifting from staff/program-centered treatment to client-centered recovery support, staff members are no longer the orchestrators of recovery initiation. This transition required considerable adjustment at Dawn Farm.

> *Staff used to be routinely invited to a client's first open talk. This was often a point of considerable pride, particularly when clients spoke of their counselor changing their lives. This is no longer the case. Today, clients are more concerned about their sponsor, sponsees and friends in recovery being there. Staff struggled a lot with this change in status. At first, it injured their pride and left them wondering if and why they were even needed. Those in recovery gave us less credit for their recoveries, and we were also seeing more relapses close up because we were now staying in touch with people much longer after treatment. Before, what was going on with relapsed clients after treatment was invisible to us until their readmission. Now we are present to see it all: the good, the bad and the ugly. We have developed a much deeper appreciation of the intractability of addiction and the complexity of the recovery process. It first humbled and demoralized us before elevating us to a new understanding of our role in the recovery process*.

A key part of this adjustment was learning to see treatment and recovery within a longer time perspective than the short-term processing milestones imposed by regulatory and funding agencies.

> *One of our challenges was to recognize progress even in the face of relapse. We had to get out of the mindset that every client should go through our treatment program, never use again and live happily ever after. We started recognizing clients whose successful recovery initiation spanned years rather than weeks and developing a vision of how to accelerate that process. We had to develop a clearer vision of what could be a prolonged recovery process. We also had to explore the notion of "partial recovery"—that some clients might never achieve full recovery but that their problems could be diminished, their harm to others minimized and the quality of their lives enhanced. We still worry about how to do this without lowering the bar and inadvertently diminishing hope for full, long-term recovery.*

In traditional treatment, loyalty to the program structure took precedence over and frequently dominated the service relationship. It is not an overstatement to say that loyalty to the program often superseded loyalty to the needs of an individual client. That loyalty to structure provided as much support to staff as it did to clients. The shift in this prioritization of loyalties was another loss staff experience in the transition to recovery-oriented systems of care that are obsessively focused on the recovery goal and view all methods as negotiable.

> *We went from an unconditional commitment to the program to an unconditional commitment to each client's recovery. We had to step back and discover that recovery was not always conditioned on compliance with our "program."*
>
> *It is more beneficial and less personally stressful to motivate clients than to try to control them. My role is not to force clients to see things my way; it is to help them make decisions and remain with them through the consequences of those decisions. We (therapists) are now looked upon as allies rather than jailers.*
>
> *As an organization, we had to move from fear and control to faith and encouragement. Escaping our preoccupation with rules and our affinity for confrontation was a major*

challenge. It was hard to think outside the box and get out of our comfort zone with individual clients.

Before when clients left against staff advice or were discharged, we never saw most of them again. Now we know what happens to all of our clients after they leave us. It's a totally different kind of relationship. Before, clients who relapsed were afraid to run into us in the community. Now they seek us out.

Such commitments require that staff engage and sustain engagement with the most impaired clients under the most difficult circumstances. If we are truly committed to helping our clients, then we must sustain the continuity of that commitment over time—being with the client and his or her family regardless of the client's successes or failures. The depth of that commitment is illustrated in the following story.

Michael was a 32 year-old heroin addict who, prior to his first treatment admission, had spent most of the last eight years estranged from his family and homeless in Seattle. He completed residential treatment, moved into sober housing and relapsed after 6 months clean. His relapse lasted only a few weeks but it ended in a severe overdose which resulted in physical limitations that lasted months and short term memory problems that persisted for several years. He was readmitted to residential treatment immediately following his discharge from the hospital, completed treatment again and stayed drug-free for 9 more months with the support of sober housing, vocational and neurological services. Relapsing again, he overdosed within one week and was readmitted to the hospital. At this point he had been abstinent for most of the last two years and had accumulated significant recovery capital but was clearly unable to remain abstinent without significant support. He did not fit into any of our programs – it made little sense to put him in residential treatment for another 2 to 6 months and it was clear that he has not stable enough for transitional housing. We met with Michael and developed a plan that started with readmitting him to residential treatment with the expectation that he would stay for 2 to 4 weeks with the goal of re-stabilizing him. His recovery plan focused on creating structure and meaning in his daily schedule and running on a daily basis so that he could achieve a previously identified goal of completing a marathon. Following this brief residential episode, he entered transitional housing with a structured schedule that included volunteer work at the homeless shelter and Detox, returning to treatment one day per week, obtaining supported employment and regular contact with our street outreach worker. Our outreach worker monitored his activity on his recovery plan, and supported him in developing solutions as new barriers to stable, long-term recovery were identified. Unfortunately, Michael once again achieved six months recovery and relapsed. Our staff talked to him regularly throughout his relapse and offered services and support. He eventually detoxed in another program and was transferred to our residential program for stabilization and developing a new recovery plan. During this stay he left treatment against staff advice and fatally overdosed. We hosted his memorial service in one of our facilities. It was attended by 350 people, including family and members of the recovering community. His mother expressed gratitude for the opportunity to reunite with her son, and other friends and family reflected on the gift he had been in their lives over the past 3 years.

Absorbing such painful losses is not easy. Moving to a recovery-oriented system of care deprives staff of some of their traditional status and rewards, generates new rewards and new stressors by more closely connecting staff to the post-treatment recovery and re-addiction experiences of clients, and replaces the structure of "the program" with demands for more individualized and sophisticated service procedures. The question then is how staff members

sustain themselves through this transition. If such transitions are to be successfully achieved, it must be done so through the vehicle of clinical supervision and peer-based supports.

Again, the concept of parallel process applies. The partnership that guides recovery support relationships must be mirrored in the supervisor-supervisee relationship. Just as the frontline service providers give up there expert role in the RM model, supervisors also give up this role and enter into partnership with counselors and clients to make the best possible decisions to further the recovery process and, when necessary, correct those decisions.

One such strategy of supervision involves the assignment of learning cases as part of each clinician's training plan. The training plan mirrors client recovery plans in their focus on strengths and barriers based on personal assessment, supervisory observations during live and formal supervision, and measures that can be used to underscore the therapeutic barriers with a particular type of case. Clinicians are assigned no more than two learning cases per caseload as part of this learning process. Through this process, clinicians are challenged to recognize and understand the sources of personal biases and other factors that can influence the assessment, treatment planning, and the recovery process. One residential therapist in Philadelphia describes the benefit of learning cases:

> *I think having learning cases is a pertinent part of our learning process. It is very difficult at times but the accessibility of supervisors along with supervision proves to be a great help in our professional development.*

Two important issues demand greater attention in clinical supervision within the recovery management model. The first involves the role ambiguity and role conflict that can come from involving a greater number of recovery support roles within the treatment experience. Supervisors may find the DBH/MRS monograph *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity* (White, 2006) a helpful resource on how to minimize and manage such ambiguity and conflict.

A second issue is the greater degree of ethical ambiguity that can arise in reducing the power differential between service providers and service recipients and extending the duration of contact. The longer duration of contact provides greater opportunities for problems of transference and countertransference and issues of race, power and privilege to arise within the service relationship. This is particularly true within new recovery support specialist roles that have not yet formulated their own folk wisdom and ethical guidelines on the management of such issues. If behaviors are categorized ethically as always okay, never okay, and sometimes okay and sometimes not okay, the latter category is much larger within the RM model than in the acute care model where ethical standards are modeled on brief psychotherapy. The RM model requires a greater level of time to process ethical dilemmas that arise with service relationships. DBH/MRS and the Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT) are currently collaborating on development of training materials and ethical guidelines for peer-based recovery support roles.

Recovery management also engenders a paradox: at the same time treatment providers abandon the expert role, they take on greater accountability for treatment outcomes. That means that a poor outcome must be examined beyond what the client did or did not do to what we as service providers did and did not do. The partnership model demands that we examine for each service outcome how well we held up our end of the service collaboration. Such self-examination requires personal and professional courage and considerable support from the supervisor. Here's how one program is attempting to manage this challenge.

> *We are trying to abandon excessive use of our own authority and focus more on the clients' making informed decisions about their family relationships, living situations, employment, and personal relationships. In the past, we accepted the power of such decisions but were uncomfortable with such power and felt crushed by the responsibility*

that came with it. There's an intense feeling of relief at not making these decisions, not bearing the burden of making the right decision, and not trying to coerce the client into executing the decisions we want them to make. The accountability now goes both ways. In the past, I think clients and staff would point the finger at each other after a relapse. Today, both parties are much more willing to examine and accept responsibility their own decisions and actions. Today staff may feel less responsible for relapses, but more responsible for maintaining engagement.

Role of the Client

In recovery-oriented systems of care, what the client wants matters. The client is expected to become an expert on the management of their own recovery process, with professional staff serving as consultants in this process. A philosophy of choice is utilized in which each client takes progressively greater responsibility in setting his or her own recovery goals and strategies and directing their ongoing recovery process. Implementing a choice philosophy within mainstream addiction treatment faces numerous obstacles: 1) challenges in the timing the application of choice philosophy with clients whose active addiction, fragile early recovery, developmental immaturity, cognitive impairment and lack of pro-recovery social support can lead to destructive decision-making, 2) restrictions on treatment philosophies and techniques imposed by referral sources, 3) conflicts between client choices and program philosophies, 4) counselor biases, and 5) inadequate knowledge and skills to facilitate the choice process. Counselors and other service staff who possess a limited understanding of recovery pathways may have great difficulty with this transition to a choice philosophy (White & Kurtz, 2005).

This suggests the importance of the clinical supervisor in training staff on the pathways and styles of long-term recovery, processing countertransference regarding pathways of recovery, sorting the limits of choice in face of active addiction and cognitive/behavioral impairments; assessing changes in volitional control will over time; and supporting staff as clients make bad choices or go through bad choices to better choices. Perhaps more than anything, recovery oriented systems of care place great emphasis on the importance of listening—REALLY LISTENING—to each client and listening to them during every step of the service process.

When staff who have worked within systems transitioning to more recovery-oriented care are asked how the role of clients has changed in their programs, they offer comments like the following:

- *It has made me realize the importance of client input into service planning as well as the benefits of their developing goals and achieving them. It benefits client to assume responsibility and accountability for their treatment and its outcome.*
- *Clients now have a major voice in their treatment. When clients are allowed to participate in treatment planning, goals and objectives and see their goals written in their words, there is deep internal buy in to the work involved.*
- *My view of the client's role in treatment has changed from clients doing what we say to me listening to them. Clients have more say and we are more helpful because we let them tell us what they want to address. The client's role is a much more assertive one.*
- *Over the past year or so, I have noticed a greater sense of accomplishment among our clients. I feel that this is a result of the change in traditional "treatment planning" and the role of the client, which internally begins with engagement*.

The following Philadelphia case study illustrates client-focused goal-setting in the service planning process.

Marquis is a 56 year old male with a 30 year history of crack/cocaine and alcohol abuse. He's had several suicide attempts throughout his life and appeared somewhat hopeless when entering Gaudenzia. After meeting with Marquis' counselor to review clinical documentation, the treatment plan was blank. The counselor discussed with me his questions about developing Marquis service plan. Marquis' number one goal was to open a savings account. In 56 years, he had never had a bank account, nor saved more than a few dollars. The counselor had difficulty understanding why it was important to put this goal on the service plan, before discussing the "role of the client" and the recovery model with his Supervisor. Marquis is now completing our program and has a savings account at a local bank with almost $1000. Again, the sense of accomplishment from simply opening a bank account, improved the client's overall motivation towards treatment and long-term sobriety.

Service Team

Recovery management models include four dimensions that profoundly shape the service delivery team: 1) openness to multi-agency, multidisciplinary service delivery models, 2) the inclusion of new service roles (e.g., recovery coaches), 3) the inclusion of local indigenous healers within service delivery teams, and 4) inclusion of peer volunteers.

Addiction treatment organizations are part of a categorically segregated service system in which relationships between innumerable specialty agencies are often characterized by isolation, competition and conflict. In isolation, these agencies are woefully ill prepared to respond to the needs of individuals and families with multiple problems and few internal and external resources to resolve those problems. Clients with multiple co-occurring problems have become the norm in addiction treatment programs in the United States, and there is growing evidence that the integrated care of medical, psychiatric and substance use disorders generate outcomes superior to parallel or sequential care (Weisner, Mertens, Pathasarathy, Moore, & Lu, 2002; Samet, Friedmann, & Saitz, 2001; Minkoff, 1989; Muser, Noordsy, Drake & Fox, 2003).

The challenge for the clinical supervisor is most critically one of time. Brokering relationships with other organizations often falls within the responsibilities of the supervisor and creates an additional source of competition for the time to do adequate supervision of service staff. The same can be said for the development of volunteer programs. The best short-term strategy to resolve this dilemma is for the clinical supervisor to delegate some of these functions to senior clinical staff. The use of multi-agency teams is also reflected in the actual clinical supervision process in terms of minimizing parochialism and protectionism; reviewing the nature of interagency collaboration, developing strategies to resolve interdisciplinary/interagency team conflict.

The development of systems to recruit, hire, orient and train and supervise peer-based recovery support services often falls on the clinical supervisor. Fortunately, there is a growing body of literature (job descriptions, procedure manuals, etc.) to guide this process (see www.bhrm.org and http://rcsp.samhsa.gov). Working with volunteers also requires time to listen and communicate with those who volunteer, praise and honor the volunteers, and respond to an occasional volunteer whose own problems or overzealousness impair their effectiveness. RM models also rely more heavily on the involvement of recovery support roles from the broader community in the treatment process. Such roles could include sponsors, clergy, supervisors, school counselors or a community elder. Maintaining role integrity between addiction counselors, recovery coaches, volunteers, sponsors and other roles is also an integral part of clinical supervision in recovery-oriented systems of care. The goal in this process is to transfer toxic dependency on drugs to a healthy interdependency on the community, with the treatment team serving as the linking agent in that process. Below is a vignette that illustrates the power of involving the volunteer service community in the treatment and recovery support process.

James, a white 19 year old suburban heroin addict was admitted to social detox after an intervention by his family following two recent overdoses. He verbalized motivation to quit and agreed to complete a 5 day detox program, but vigorously resisted his parents pleas to enter residential treatment. The detox staff evaluated him and, based on his treatment history and recent overdoses, used motivational enhancement strategies to encourage him to consider additional treatment. He again refused the recommendation. On his 4th day of detox, James was asked to help a young tattooed and pierced volunteer from the recovering community prepare lunch. James and Garrett spent an hour and a half cooking, serving, eating and cleaning up lunch together. After Garrett left, James asked to talk to staff about arranging his admission to residential treatment. He explained that talking with Garrett changed his view of what recovery is. James' recovery career was enhanced by the creation of physical, social and temporal space where such an encounter could occur.

Moving toward recovery-oriented systems of care also requires programs to move from isolation from other agencies toward the development of multi-disciplinary, multi-agency service delivery models. As the following vignette illustrates, such a shift requires getting through old history between agencies that fuels conflict rather than collaboration. Here's an example of that process.

Mark was a 46 year old male who was court referred to Dawn Farm for residential treatment for alcoholism. His history of alcohol problems extended back to his early 20s, including several prior treatment episodes. He was released to treatment from jail after serving several months in jail for felony assault charges for choking his wife to unconsciousness. The judge ordered him to complete residential treatment and a particular local batterer intervention program (BIP). He had no prior criminal involvement and insisted that he was in a blackout (police reports indicate a high BAL), had no memory of the incident and had never abused her before. However, his wife disputed his report and his interactions in the treatment milieu quickly revealed interpersonal dynamics of power and control.

We requested that the judge consider referring him to another BIP because we were concerned that the BIP would discourage participation in mutual aid groups. Several years earlier Dawn Farm received a document from the BIP that accused treatment providers, 12 step groups and the disease model of colluding with batterers. The document went so far as to compare 12 step meetings to a men's locker room of a restricted country club. Dawn Farm decided that the BIP was a program that we could not and would not work with, fearing that any referral to the BIP would be discouraged from attending 12-step meetings and severely undermine recovery progress. As a result there had been no communication between the two programs for several years.

The judge refused the request and asked the probation officer to convene a meeting between Dawn Farm and the BIP. Both programs brought their concerns to the table, listened to each other's responses and decided that there was enough common ground to continue the dialogue. (It is worth noting that both programs were going through significant internal changes that made them much more open to questioning their assumptions and learning from each other.) After several lengthy discussions about all of the concerns on both sides, we were able to find sufficient common ground to proceed on with the assumption that we could work effectively together and not undermine the other.

We facilitated Mark's concurrent participation in the BIP and spoke weekly to discuss progress and concerns–about Mark's case and the relationship between the organizations. We talked extensively about our distinct philosophical underpinnings and how to maximize reinforcement/compatibility and minimize interference. Both agencies quickly became grateful for each other's involvement in Mark's case. He was exceptionally well defended and was challenging for staff in both programs. It was clear that his prognosis would have been poor in either program alone. We appreciated each other's reinforcement of accountability and became convinced that this collaboration dramatically improved his prognosis for both problems.

Counseling and Treatment

Programs attempting to do more recovery-oriented care find their core treatment services changing in a number of significant ways, including greater reliance on evidence-based treatment approaches, an emphasis on constant re-engagement and service retention, and a shift away from "programs" to menus of treatment and recovery support services that are individually combined and sequenced. Clinical supervisors report greater use of skill-based training (e.g., MET and CBT), more sophisticated systems of fidelity monitoring (e.g., emphasis on adherence to clinical protocol), and a decrease in "psychobabble". These shifts involve making the services fit the needs of the client and not the client fit the services. They also require cooperation from funding and regulatory agencies whose structures may inhibit such individualization of care.

Other changes are evident in the shift to recovery management. There is a shift from providing services <u>within</u> a particular recovery pathway to providing services <u>across</u> recovery pathways. This requires a greater knowledge on the part of staff in the multiple pathways and styles of long-term recovery and potentially more countertransference issues related to staff feelings about particular pathways and styles of recovery. The tenor of service planning shifts from confrontation and indoctrination to one of education, choice clarification and sustained support.

The shift from treatment planning to recovery planning also involves an expansion of resources needs (educational, vocational, housing, health, leisure, etc.). Treatment becomes viewed as something beyond inpatient and outpatient services. This requires a greater knowledge of community resources on the part of staff and the clinical supervisor and greater care in sequencing activities to avoid overwhelming both clients and staff.

Here are a few examples of how core treatment services and their supervision are changing in the move toward more recovery-oriented systems of care.

<u>Evidence versus Belief</u> *There is a collision going on between new scientific evidence and personal and program beliefs. We continue to disagree even when we are presented with sound research. People are passionate about their ideas about addiction and its treatment and reconciling those ideas and the latest research findings is a critical aspect of clinical supervision.*

<u>Out-of-the-Box Thinking # 1</u> *Thomas was a self-referred Black male addicted to injection heroin and crack cocaine with what seemed like every possible complicating factor, maternal heroin addiction, traumatic war experiences (Vietnam), years of homelessness, past prison time, past enmeshment in the mental health system, multiple prior addiction treatment episodes and chronic health problems. Everything about Thomas suggested a need to long-term, high intensity services. He was admitted to long-term residential treatment and quickly proved to be intelligent, highly motivated to recover, hard working and insightful. He also was hyper-vigilant, intolerant of his peers, constantly in conflict*

with other clients, prone to explosive outbursts that were sometimes difficult to de-escalate. Staff reached a point where they felt Thomas' presence was too disruptive to the treatment milieu and that he should be discharged. But rather than terminate Thomas' relationship with the agency, we transferred Thomas to a new transitional housing program that included no treatment or clinical programming. The idea of providing Thomas support in a less rather than more structured environment was very counter-intuitive, but his improved functioning in this setting confirmed for us that some clients with high problem severity and complexity do better with less rather than more structure.

Out-of-the-Box Thinking # 2 *Edward was a middle-aged Black crack cocaine addict court ordered to treatment for violating his probation via several positive drug screens. He was intelligent, articulate, socially engaging and supportive of struggling treatment peers. He was also arrogant, sexist, resentful of any authority (particularly female authority) and was often disrespectful to other clients and staff. He verbalized motivation to recover and exhibited impressive insight, but questioned the need for residential treatment and resented the alternative of six months in jail.*

The counseling staff, constantly frustrated with Edward's overt refusal to yield to their authority and expertise, finally had had enough. Believing his attitude was too disruptive to the treatment milieu, they recommended his discharge for failure to progress. In staffing his decision, our program director asked how he was doing in the recovering community. After all, he suggested, our mission is "to remove barriers that prevent addicts from joining the recovering community." It turned out that Edward had developed an impressive support system. He had more than a dozen men in stable recovery with whom he spoke regularly, received rides to 12 step meetings, and spent his leisure time. When queried, these men reported that Edward was doing very well as a newcomer to 12-step recovery other than his resentment about his mandated treatment. He was eagerly doing step work, had accepted service commitments at two meetings, saved money to attend a weekend recovery retreat and participated fully in meetings.

The President challenged the staff's decision to discharge Edward by pointing out that our goal was recovery, not treatment compliance and that Edward seemed to be making significant progress toward that goal. He forced us to think beyond the question of progress in the house to look at progress in connection to the recovery community. We were achieving our mission with him. His challenges forced us to look at ways we could build on Edward's true recovery progress and more effectively diffuse Edward's resentment about being mandated to treatment. Cases like this have taught us to distinguish between treatment progress and recovery progress.

These shifts in clinical orientation have obvious implications for the recruitment, hiring, orientation, training and supervision of staff. Based on our experience to date, some individuals will have difficulty with these transitions, particularly those counselor's who must be the charismatic center of their clients' recovery experiences and those who view recovery within a very narrow recovery pathway.

Locus of Services

Recovery-oriented systems of care shift the focus of care from getting individuals into treatment (getting them from their environment to the treatment environment) to nesting and anchoring the recovery process their own natural environments or, when that is not possible, to create an alternative environment in which their recoveries can flourish. That involves a greater emphasis on home-based and neighborhood based service delivery and in creating physical communities of recoveries where support for recovery is particularly rich (e.g., developing and linking recovery homes with local recovery communities). The extension of services into natural

environments raises new issues in supervision (e.g., etiquette and ethics of home visits, safety management) that have historically not been issues in residential and outpatient treatment settings. Part of Dawn Farm's renewal process involved extending its reach into the community through assertive outreach programs. The following report from a person delivering outreach services in the jail illustrates the potential of such efforts.

> *I met Merwyn when he came to my jail program. He's a 52 year old heroin addict who has done a few prison stretches totaling about 7 years. He was in this time for theft and possession. He completed the 30 day program in the jail and was scared about the prospects of what would happen after his release. I told that if he met me at a 12 step meeting the night he was released, I'd help him get a job. When he showed up at the meeting, I connected him with some solid guys in recovery and made sure he left with several phone numbers. I also gave him my cell phone number and told him to be sure to call me the next day and I'd check some connections about getting him a job as a cook. I hooked him up with a job with someone who would respect his recovery and his need to go to meetings. When he decided he needed a safer place to live, I helped him get into a half way house. He did well there, and he's started working for them part time. He's reconnected with his kids and he's now very involved in the recovering community. The guys I meet in the jail program know that a lot of workers would be scared if they bumped into them on the street. It makes a big difference when they know you care about them, you aren't scared of them and you're willing to help connect them with jobs and stuff – it's like they're honored that you'll cash in some chips for them.*

Duration of Services

Recovery management models maintain a much longer duration of service contact than do acute care models but do so generally at less restrictive, less intense levels of care. The goal is to provide lower intensity recovery supports for longer periods of time to enhance the durability and quality of recovery, reduce the frequency and duration of any relapse episodes, and reduce the total volume of life-disrupting, expensive, acute care needed over one's lifetime. The bulk of these lower intensity services involve pre-treatment engagement contacts, in-treatment case management and recovery support, assertive linkage to communities of recovery, active recovery coaching (e.g., stage appropriate recovery education), post-treatment recovery checkups, and, when needs, early re-intervention. Here is an example of such extended contact.

> *Joe is a 51 year old male with a 34 year history of alcohol dependence. Joe is well known in the community by the police, hospitals and shelters. It is not uncommon for him to have a BAL of over .50, tell wild stories about his life, and become belligerent. We first met him in 2000 when he sought admission to residential treatment. He had 3 admissions to residential in rapid succession, eventually completed treatment and moved into sober housing. Since then, Joe has experienced what we might call serial recovery. He's achieved periods of sobriety for 18 months, 12 months and four episodes of six months. During these periods he maintains employment, housing and is a loved and active member of the recovering community. After his first episode with us, our outreach worker began working with him. Here is our outreach worker's experience with him:*
>
> *"Joe had numerous visits to our detox facility during relapses and was very difficult to stabilize. He often needed to be transferred to a medical facility because of his high BAL. When we were able to admit him he often left against staff advice or was discharged for disruptive behavior. When I would be doing outreach, I would often see him on the streets completely wasted and I just kept talking to him about recovery. I developed enough of a rapport with Joe that he frequently used me as an emergency contact. I visited Joe in the local emergency room countless times. He would often spend a week or more in the*

hospital being treated for physical problems caused or worsened by his drinking. During one particularly stretch, he ended up in the ER nearly every day for a month. I met with the ER staff and our detox staff and we developed a plan to get him into a hospital bed immediately (rather than being held in the ER for hours) to stabilize him medically, then move him ASAP to a social detox and then into sober housing. It took a few attempts but we finally got him restabilized and he's been sober for 6 months now. I've been staying in regular contact with him and we're working on strategies to keep him in stable recovery."

The key to the success of the RM model rests on continuity of contact in a primary recovery support relationship over time. This means within service planning that we can look beyond a single episode of service to the larger trajectory of the recovery process. This helps staff escape get staff away from the "one bite at the apple" mentality in which more and more activity is jammed into less and less service time. The ability to monitor responses to various recovery strategies allows refinement in these strategies over time and avoids each client needed to cycle through episodes of treatment until they encounter the right combination of services at the right time to solidify the recovery process. The extended period of contact also poses less risk of overwhelming client by trying to address all issues within the narrow window of recovery initiation. Sustained recovery management provides more stage-appropriate integration of issues as an alternative to the frenzy of trying to address everything in X sessions or X days.

The role of the clinical supervisor in the RM model is to help staff think beyond the frameworks of admission, treatment and discharge; establish protocol for continued monitoring and support; and monitor the quality of on-going recovery support relationships, including the maintenance of appropriate boundaries within these relationships. The latter is challenging when relationships are less formal and extended over such long periods of time. The application of ethical standards based in clinical roles and an acute model of care may not be applicable to non—clinical recovery support services provided within a model of sustained recovery management. For example, the typical prohibition against gift-giving and gift-receiving designed to prevent exploitation of clients within the acute care model may actually do harm or injury to clients and the service relationship within the recovery management model, e.g., personal or cultural offense taken at a recovery coach's refusal of a gift from a client. As the relational models and service duration change, such issues will need to be carefully reviewed in supervision, with ethical and professional practice standards evolving in tandem with new learning.

Discharge and "Aftercare"

The shift from acute models of intervention to models of sustained recovery management requires a radical re-thinking of traditional "aftercare" services. In contrast to traditional aftercare models, assertive approaches to continuing care:

- encompass all admitted clients/families, not just those who successfully "graduate," including those who terminated treatment against staff advice or were administratively ("therapeutically") discharged,
- place primary responsibility for post-treatment contact with the treatment institution, not the client,
- involve both scheduled and unscheduled contact (e.g., "I've been thinking about you today and thought I would call to say hi and see how things were going."),

- capitalize on temporal windows of vulnerability (saturation of check-ups and support in the first 90 days following treatment) and increase monitoring and support during periods of identified vulnerability,
- individualize (increases and decreases) the duration and intensity of check-ups and support based on each client's degree of problem severity, the depth of his or her recovery capital and the ongoing stability or instability of his or her recovery program,
- utilize assertive (see discussion below) linkage rather than passive referral to communities of recovery,[4]
- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support and mailed and emailed communications,
- place emphasis on those combinations and sequences of services/experiences that can facilitate the movement from recovery initiation to stable recovery maintenance,
- emphasize support contacts with clients in their natural environments,
- may be delivered either by counselors, recovery coaches or trained volunteer recovery support specialists, and
- emphasize continuity of contact and service (rapport building and rapport maintenance) in a primary recovery support relationship over time (Dr. Mark Godley, Director of Research, Chestnut Health Systems, personal communication, February, 2006)(Excerpted from White & Kurtz, 2006b).

RM models of care eliminate rituals and words that communicate to clients with severe AOD problems and to staff that recovery is something to be achieved in a short period of time. RM leaders advocate abandonment of such concepts as "graduation," "discharge" and "aftercare" for those with severe complex substance use disorders on the grounds that those terms have no utility in the management of other chronic health disorders, e.g., diabetes, hypertension, asthma, chronic pain. Treating severe and chronic substance use disorders in brief, self-encapsulated episodes of care makes no more sense than treating diabetes only through repeated treatment of diabetic coma in a hospital emergency room. The "aftercare as afterthought" mentality has to be abandoned and replaced with the understanding that continuity of contact and support over time is the very essence of chronic health care management. Fulfillment of that shift will not be possible without policy, regulatory and fiscal alignment with that vision, but there is much the clinical supervision can do in the interim. Here are a few suggestions.

1) Retool the language within the treatment milieu in ways that reflect this long-term recovery vision,
2) Streamline the movement between levels of care and the ability of clients to for brief re-stabilization or support,
3) Establish simple protocol for post-treatment monitoring and support,
4) Explore the potential of using alumni and other trained recovery volunteers to provide telephone-based, post-treatment recovery coaching,
5) Collaborate with local recovery advocacy/support organizations that specialize in recovery support services.
6) Do not underestimate the enormous import of the shift from an acute care model to an RM model at programmatic, staff and client levels.
7) Actively manage demoralization of staff, clients and families by framing severe AOD problems within a chronic disease framework that holds out the promise for eventual recovery.

Referral is not linkage; it is affirmation of the need for linkage and the hope that linkage will happen. Linkage is a process that assures that the connection between an individual and indigenous recovery support systems really happens.

Members of the Philadelphia Clinical Supervision Work Group felt very strongly about the important of post-treatment monitoring and support for all clients, not just those who successfully complete treatment. The following comment is reflective of these sentiments.

> *Recovery is not always defined or conditioned on compliance with a program. If those clients who leave "ASA" or were "administratively discharged" are followed or even directed to outside/community supports, their chances for maintaining sobriety would increase. I feel this area is one that needs emphasis in transitioning to the recovery model.*

Other examples of such supports included phone contacts to clients, invitations to come back to the facility to speak about life in the early stages of transition to the community, sponsoring a client-driven support group that include current clients in treatment and those who have transitioned into the community.

Advocacy and Recovery Community Development

Recovery management blends traditional clinical models of care with models of community organization and community development. The latter seek to reduce forces in the community that promote AOD-related problems or create obstacles to recovery and to expand community recovery capital. Treatment agencies are called upon to look beyond their institutional interests and advocate for broad community changes that have enormous impact on the recovery climate and specific recovery supports but may not increase dollars coming to the agency. Such activities can range from broad recovery advocacy activities (e.g., participating in local anti-stigma campaigns and recovery celebrations) through helping expand recovery support resources (e.g., development of specialty support meetings). They can also involve organizing supports for a particular client, e.g., setting up recovery supports inside the high school that a client will be returning to upon her completion of primary treatment. Here is an example of how one program launched a recovery advocacy educational campaign.

> *One day we were sitting around venting our frustration that the public imagines all addicts as some guy who breaks into homes and steals TVs. We talked about the need to raise awareness that people come in contact with recovering people every day—that recovering people are cashiers, carpenters, chefs, doctors, clergy, teachers, nurses, homemakers, lawyers, etc. We decided to start an advertising campaign that would present recovering people and their loved ones, the goals were to normalize recovery, offer hope and reduce the stigma associated with addiction. We believed that it was important to avoid any appearance of self-promotion, so the ads deliberately excluded any mention of our organization. We eventually created posters, postcards, wristbands, calendars and CDs with ads that could be run in any publication. All of the materials are available free to anyone who would agree to use them only to promote recovery (not any programs or business interests) (See recoveryiseverywhere.com). We've asked for donations to cover our costs, but don't require them. It's been important for the organization that we live the values we talk about and take action to support recovery beyond the walls of our treatment center.*

Such activities are not without their problems. The scope of needs for expanded recovery supports can be overwhelming, leaving the clinical supervisor and clinical staff pondering how to best allocate limited time and resources. Staff time spent on unfunded, out of office activities must also be monitored in clinical supervision to avoid shifting too far from clinical support to community resource development. Perhaps more than anything, this extension of the role of clinical staff involves a major redefinition of professional identity and over time a redefinition of the role of the agency in the community.

How is this possible?

Most readers will have already declared numerous times: "How would all of this be possible?" It is an appropriate question. Many broad changes in the field are necessary to fully embrace more recovery-oriented approaches to addiction treatment, including:

1) regulatory relief on the type and quantity of service documentation
2) development of financing models for pre-treatment, in-treatment and post-treatment recovery support services
3) reduction in staff turnover at front line service levels
4) enrichment of clinical supervision via its frequency and quality
5) technical support for development of peer-based recovery support service models, e.g. hiring, orientation, training and supervision protocol, a code of ethics for peer-based recovery support specialists.

We have attempted in this paper to outline the future evolution of addiction treatment and the role of clinical supervision in the movement toward more recovery-oriented systems of care, but we must return to an initial point in this paper. As administrative demands have increased on the supervisor and as paperwork demands have increased for clinicians, supervision has become an exercise in making sure the clinician is complying with all documentation and reports. Change must come from two directions. First, funding and regulatory agencies must find a way to reduce and minimize service documentation requirements. Such relief is essential if the focus on client needs (versus institutional needs) is to be restored. Second, clinical supervisors must become activists within their own agencies in pushing for changes that maintain or restore the integrity of core recovery support services and the service relationship.

The transition from services that focus on acute biopsychosocial stabilization to services that support long-term recovery will be a difficult one, with innumerable obstacles and pitfalls. Supervisors can expect considerable resistance from staff and also from clients ingrained in old styles of treatment.

> *It was very difficult at first to make this shift from control to support. The clients were in an uproar because they felt that their peers were getting away with all kinds of mayhem, and many staff felt the same way. We had an easy way to handle the clients whenever they would not follow our direction—the shit pile [work detail]. That was our answer for just about everything…if you don't like it, then go out to the shit pile. If you don't want to do it, than go to the shit pile. If you fall asleep in group, you go to the shit pile. There was nothing more in our recovery tool box to help the clients be accountable for their behaviors. When we shifted approaches, frustration was common amongst staff. We were sure clients wouldn't get sober under this new system and that we would ruin our reputation in the community. We resisted this change. We kept asking for a list of rules. And every time the bosses left us, we would just shake our heads because we thought they were absolutely crazy in what they were trying to do. We were scared. It took a while for us to gain an understanding of what they were trying to do. As in AA, we had to fake it until we got it. After a while, we started to believe and gain an understanding of why this change was so important.*

Success or failure with such a transition rests to a great extent on the role of the clinical supervisor. For success, the supervisor must nurture development of a chain of support within the treatment milieu. Clinical Supervision must provide the support for continued engagement and service activity during early periods when staff may see little measurable progress and few words of appreciation coming from clients.Support from the supervisor, professional peer

support and feedback from clients in stable recovery are crucial to sustaining the motivation of staff in working with clients in the early stages of recovery.

One of the guiding concepts in clinical supervision has been that of parallel process. Searles (1955) first defined parallel process as the re-enactment of processes within the therapist-patient relationship in the therapist-supervisor relationship. What is important about this concept for our current discussion is Doehrman's (1976) discovery of the bi-directionality of parallel process, namely that key aspects of the supervisor-therapist relationship are replicated in the therapist-patient relationship. What this means at a practical level is that we can promote the counselors' use of a strengths-based approach by modeling that approach in our style of clinical supervision. If we want counselors to understand and utilize stages of change theory in their work with clients, we need to illustrate the application of that theory in our own work with the professional development of our counselors. If we want the counselor's work with each client to be focused on recovery, then that focus must be modeled within our supervision of each client's service process. If we want each counselor to demonstrate a depth of knowledge about diverse pathways and styles of recovery, then we must become students of and demonstrate respect for such pathways and styles. We close this article more convinced that ever that the role of the clinical supervision is critical to the development and maintenance of recovery-oriented systems of care. Clinical supervision occurs within a hierarchical relationship much the same way that the therapist/client relationship is hierarchically ordered. For clinical supervision to be effective, it must empower the staff so they can best understand the strengths they bring to their service relationships in much the same way they will empower clients by focusing on the client's strengths--a positive twist on the notion of parallel process in supervision!

Acknowledgment: Support for the preparation of this paper was provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services. The opinions expressed here are those of the authors and represent, not DBH/MRS policy, but an effort to facilitate discussions within and across treatment agencies as part of the DBH/MRS system transformation process. We would like to thank the participating agencies for opening themselves to the kind of self-examination reflected in the paper.

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Citation: Gagne, C. A., White, W., & Anthony, W. A. (2007). Recovery: A common vision for the fields of mental health and addictions. Psychiatric Rehabilitation Journal, 32(10), 32-37. Posted at **www.williamwhitepapers.com**

Recovery:
A Common Vision for the Fields of Mental Health and Addictions.

ABSTRACT

The vision of recovery is reshaping the fields of mental health and addiction services. This paper reviews how this broad vision is shaping common goals, principles, values and strategies across the two fields. We further examine how a common vision of recovery can positively impact the treatment of co-occurring disorders and speculate on how this vision can bridge the seeming differences between these two fields and reshape a mutual understanding of the essentials of recovery from severe mental illness and addiction.

Concept of Recovery in Mental Health: Current Perspective

In the field of mental health the recovery vision was introduced and most often discussed in the writings of people with psychiatric disabilities (e.g., Anonymous, 1989; Deegan 1988; McDermott, 1990; Ralph, 2000, 2004; Unzicker, 1989). Empirical support for the promulgation of the recovery vision in mental health has been by means of the synthesis and dissemination of numerous long-term outcome studies (Harding & Zahniser, 1994; Harding, in press), which suggested that a significant percentage of people with severe mental illnesses were dramatically improving over time. Currently, there are 10 national and international longitudinal studies of 20 to 30 years demonstrating that recovery is possible for at least one-half of people with schizophrenia and other severe mental illnesses (Bleuler, 1972; Ciompi & Muller, 1976; Desisto, Harding et al., 1995 a and b; Harding, Brooks et al., 1987, a, b; Hinterhuber, 1973; Huber, Gross & Schuttler, 1979; Kreditor, 1977; Marinow, 1974; Ogawa et al., 1987; Tsuang, Woolson & Fleming, 1979). Furthermore, a review of systems-level literature and mental health policy statements suggests that even though heretofore there has been no explicit consensus about the meaning of the term recovery, the vision of recovery is now guiding policies and practice in many state mental health systems (see for example, Onken, et al., 2002; Jacobson & Curtis, 2000; Legislative Summer Study Committee of the Vermont Division of Mental Health, 1996; State of Nebraska Recovery Work Team, 1997; State of Wisconsin Blue Ribbon Commission on Mental Health, 1997), as well as in entire countries like New Zealand (Lapsley et al., 2002) and the U.S. (Presidents' New Freedom Commission on Mental Health, 2003).

Concept of Recovery in Addictions: Current Perspective

In the addictions field, the use of the concept of recovery as an organizing construct for transformative change pre-dates the rise of formal addiction treatment (White, 1998). The field's conceptual center has subsequently evolved through a focus on pathology (the study of AOD problems as medical diseases) to treatment (medical, psychiatric, and psychological interventions into AOD problems) to a re-emerging focus on recovery (prospects and processes for long-term resolution of AOD problems) (White, 2004a; White, in press). There is growing interest in the multiple pathways and styles of long-term recovery and in the international diversification and growth of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004b). A new addiction recovery advocacy movement (see www.facesandvoicesofrecovery.org) led by recovering people and their families is calling for a reconnection of addiction treatment to the larger and more enduring process of personal and family recovery (Elsie, 1999; White, 2000). Frontier issues within this re-emerging recovery focus include struggles to define recovery and its conceptual and linguistic boundaries (White 2002), efforts to measure the prevalence of addiction recovery in America (Road to Recovery, 1998), calls for a recovery research agenda (White, 2000), a shift from the current acute models of problem intervention to models of sustained recovery management (McLellan, et al, 2000; White, et al., 2003) and the growth in peer-based models of recovery support services (Jason, et al, 2001; White, 2004c). This renewed recovery focus is evident in the White House initiated Access to Recovery program, the Center for Substance Abuse Treatment's Recovery Community Support Program, and in state efforts to develop more recovery-oriented systems of care (see http://www.dmhas.state.ct.us/policies/policy83.htm).

Common Characteristics between the Two Fields

The fields of mental health and addiction share a dark past in which people experiencing the psychiatric and/or addiction disorders endured institutions that offered ineffective, if any, treatment. Each disorder was considered to be intractable and stories of recovery were rare. People living with either disorder were expected to end up in the least favorable places in society, the gutter, prisons, asylums, or morgues. Throughout history, both systems of care have been distracted by debates about the causes and nature of the disorders, troubled by widespread prejudice and discrimination, and undermined by the criminalization of behaviors associated with the disorders. Even today, addiction and mental illness occupy a common space of disgrace in society.

Examining the characteristics influencing recovery from addiction and recovery from mental illness, it is astonishing that the two fields have not collaborated to organize services under a common vision of recovery. (See Table A). People living with psychiatric and/or addiction disorders want to eliminate or manage their symptoms, increase their capacity to participate in valued roles, and embrace purpose and meaning in their lives, in other words, experience recovery. People in recovery from mental illness and/or addiction disorders are leading the call to change the current service systems of care to become recovery-oriented.

The principles of a common recovery vision begin with the notion that for both disorders, recovery is a personal and individualized process of growth that unfolds along a continuum and that there are multiple pathways to recovery. First person accounts of people in recovery from addiction or mental illness have described recovery as a transformational process and an incremental process, and recovery stories are often filled with elements of both styles of change. First-person narratives of recovery from addiction and mental illness reveal the individualized nature of recovery processes. Also made clear within these stories is that people in recovery are active agents of change in their lives and not passive recipients of services. People in recovery from mental illness and/or addition disorders also often note the role of family and peer support in making the difference in their recovery.

The values of recovery-oriented mental health and addiction systems are based on the recognition that each person is the agent of his/her own recovery and all services can be organized to support recovery. Person-centered services that offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction have a place in a recovery-oriented system. These values can be operational in all services for people in recovery from mental illness and/or addiction, regardless of the service type (i.e. treatment, peer support, family education etc.).

Differences that have existed in the recovery visions of the mental health and addictions fields could provide opportunities for synergistic growth in both fields. For example, the addictions field has had a well-developed concept of full recovery but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but has, until recently, lacked a viable concept of full recovery (Fisher & Ahern, 1999; White, Boyle & Loveland, 2004). Integrating the concepts of full and partial recovery within the emerging recovery visions of both fields holds great promise.

Reshaping the Future of both fields under a Recovery Vision

Presently neither the mental health nor addiction treatment system is designed to assist people in their recovery from mental illness and/or addiction. Both fields have had to acknowledge the limitations of the institutionally based "acute model" of treatment to bring about lasting recovery. Over the past 30 years, mental health system has reorganized to offer support services in the community, while the addiction field continues to deliver primarily a model of acute care with little on-going community support. Guided by a vision of recovery, the mental health and addiction fields could organize their services to address the often long-term and complex needs of people living with mental illness and/or addiction, including people severely disabled by co-occurring disorders. People who are living with co-occurring psychiatric and addiction disorders could be well served in service systems united under a common vision of recovery. Much has been written about the failures of the mental health system and the addiction system to provide people with co-occurring disorders with the long-term services and supports often needed to promote recovery (Drake et al., 2001, Minkoff, 1989, Mueser et al., 1998). The vision of recovery would compel both systems to provide outreach to engage people in a process of recovery, motivational services to help people develop readiness for treatment and/or rehabilitation, and provision of on-going recovery support services to assist people to reach their recovery goals. Recovery support services would be located in communities, in specific environments of need, and be provided by professionals, family members, and peers.

A unified recovery vision communicates realistic hope, emphasizes the role and responsibility of the person in recovery, and recognizes the many pathways to healing and wholeness that people with mental illness and/or addiction take in their recovery. The recovery vision might influence the research agenda to shifts its focus from acute pathology to the prevalence and processes (stages and styles) of long-term recovery from mental illness and addiction. The vision of recovery will require the mental health and addiction systems to work together with people in recovery as individuals and communities to develop effective services, strategies, and supports. Finally the recovery vision encourages the development of a culture of recovery and recovery communities to assist all people who are affected by mental illness and/or addiction, in other words, most of us.

Table A: Common characteristics under a Recovery Vision

	Mental Illness	**Addiction**
Goals	To assist people affected by mental illnesses reduce the impairment and disability, and improve quality of life	To assist people affected by addiction disorders reduce the impairment and disability, and improve quality of life
Role of person with disability	Person is agent of recovery. Active involvement is necessary for recovery	Person is agent of recovery. Active involvement is necessary for recovery.
Principles	• Broad heterogeneity of population and outcomes • Focus on person and environment • Long-term perspective • Recovery is a process and a continuum • Non linear process of recovery • Family involvement is helpful • Peer support is crucial • Spirituality may be critical component of recovery • Multiple pathways to recovery	• Broad heterogeneity of population and outcomes • Focus on person and environment • Long-term perspective • Recovery is a process and a continuum • Non linear process of recovery • Family involvement is helpful • Peer support is crucial • Spirituality may be critical component of recovery • Multiple pathways to recovery
Values	• Person-centered • Partnership (person involvement) • Growth • Choice • Strengths perspective • Focus on wellness and health	• Person-centered • Partnership (person involvement) • Growth • Choice • Strengths perspective • Focus on wellness and health
Strategies to Facilitate Recovery	• Treatment i.e.: Crisis intervention, medication, therapy, illness management education • Community support (connection to peer-support and recovery organizations) • Skills for valued roles • On-going, flexible recovery-enhancing services • Advocacy	• Treatment i.e.: post-treatment monitoring, early re-intervention, medication, therapy • Community support (assertive linkages to communities for recovery) • Skills for valued roles • On-going, flexible recovery-enhancing services • Advocacy
Essential ingredients of Recovery-oriented System	• Treatment • Rehabilitation • Peer support • Community Support • Legal Aid • Enrichment • Basic Support • Family education and support	• Treatment • Rehabilitation • Peer support • Community Support • Legal Aid • Enrichment • Basic Support • Family education and support

Societal Attitudes	• Historically, prognosis was considered hopeless • Debates about cause(s) and nature of illness • Criminalization of illness • Prejudice and discrimination	• Historically, prognosis was considered hopeless • Debates about cause(s) and nature of illness • Criminalization of illness • Prejudice and discrimination

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Citation: Davidson, L & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *Journal of Behavioral Health Services and Research*, *Journal of Behavioral Health Services and Research*, 34(2), 1094-3412. Posted at www.williamwhitepapers.com

The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services

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and Chestnut Health Systems

Abstract

Despite a range of long-standing historical, political, ideological, professional, structural, and practical barriers, there has been, and continues to be, a clear consensus that integration between mental health and addiction services is sorely needed and long overdue. This paper focuses on one dimension of the challenge of integration from among the several—the conceptual—and proposes the construct of recovery as an organizing principle for bridging the divide between the two domains. After reviewing briefly the parallel history of the two traditions and their shared need for transformation to a recovery orientation, the authors offer an integrated model of recovery for persons with co-occurring disorders. They then derive from this model the underlying values, guiding principles, key strategies, and essential ingredients of recovery-oriented systems of care which comprise a common approach across both addictions and mental illness, offering a strengths-based solution to achieving integration where pathology-focused approaches have failed.

> "Treatment in parallel and separate mental health and substance abuse treatment systems . . . is remarkably ineffective" —Drake and colleagues[1, p. 361]

This conclusion was drawn by Drake and colleagues from their recent review[1] of research on the care of individuals with co-occurring psychiatric and addictive disorders. While the conclusion itself is not surprising, it is striking that this conclusion continues to be just as salient today as it was when it was first reached over 25 years ago.[2-4] Since that time, numerous reports, reviews, and research have documented well and extensively the uneasy relationship that exists between mental health services and services for persons with addictions.[5-16] Consistent epidemiological and service utilization data collected during this same period have shown that mental illnesses and addictions co-occur within the same person as frequently as they exist independently of one another. These data further call into question the current bifurcation of the

behavioral health field into two distinct and heavily bounded territories.[17-18] While work such as the review by Drake and colleagues cited above has sought to overcome this split in the field by repeatedly highlighting the importance of providing integrated care for persons with co-occurring disorders, systemic efforts continue to lag behind and to encounter numerous obstacles. These obstacles range from historical, political, ideological, professional, and fiscal/structural issues at one end of the spectrum (e.g., separate funding streams, independent state agencies) to practical and logistical issues at the other end. And unfortunately, Ridgley, Goldman, and Willenbring's[14] discussion of these obstacles more than 15 years ago remains as relevant today as when first published. Despite these long-standing and formidable barriers, there has been, and continues to be, a clear consensus in the field that integration is both sorely needed and long overdue.

This paper focuses on one dimension of this challenge from among those mentioned above: the conceptual dimension—and this for several reasons. First, previous efforts that have focused on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by these conditions, have failed to establish a common ground adequate to provide a foundation for integration. Efforts aimed at resolving the political, fiscal, and structural issues that impede integration have had minimal impact thus far, perhaps in part due to their lack of a shared conceptual framework on the basis of which a persuasive argument for integration could be mounted. Second, and more importantly, the recent emergence of a "recovery movement" in both mental health and addiction offers a potential new organizing principle for bringing these two worlds together. Persons recovering from these disorders may be offering a pathway to service integration that has thus far remained hidden to behavioral health care policy makers, planners, and managers. Integration has yet to be achieved through a focus on the nature of the disorders or the treatments required to address them; perhaps a focus on the processes of recovery, healing, and community inclusion will. As a core principle of the recovery movement suggests, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction alone have not been able to do.

Prior to making the case for recovery as an organizing principle, this paper provides a brief review of those aspects of the history of mental health and addictions which are shared and also argues that there is an equally pressing need for transformation to recovery-oriented care in both systems. A brief conceptual introduction to the notion of recovery currently being developed and promoted by the recovery movement is then offered and followed by a description of some of the areas of overlap between recovery in serious mental illness and recovery in addiction. With this common ground established, the case is then made for a conceptual integration of mental health and addiction services. The discussion focuses on the essential principles and components of recovery-oriented systems of care—approaches that aim to promote the person's resilience and recovery, and foster community inclusion and support, regardless of the nature of the conditions involved.

The parallel histories of addiction and mental illness and shared need for transformation

The fields of mental health and addiction both have a dark past in which people experiencing mental illnesses and/or addictions endured institutions that offered no treatment, ineffective treatment, or well-intentioned treatment that did harm. Each disorder was considered to be intractable and stories of long-term recovery rarely reached professional or public consciousness. People living with either disorder were expected to end up in the least favorable places in society: the gutter, prisons, asylums, or morgues. Throughout history, both systems of care also have been distracted by debates about the causes and nature of the disorders, troubled by wide-spread prejudice and discrimination, and undermined by the criminalization of behaviors associated with these disorders.[19] Even today, addiction and mental illness occupy a

common space of disgrace in society, and those suffering from these disorders are over-represented within the nation's prisons.[20-22]

At the present time, neither the mental health nor addiction treatment system is focused on supporting long-term recovery. Both systems have failed to acknowledge and overcome the limitations of their traditional institution-based and/or acute care models of treatment and rehabilitation in order to focus on the longitudinal and community-based processes of lasting recovery. Over the past 30 years of hospital closures and downsizing, the mental health system has shifted its focus to support services in the community, but in failing to acknowledge and facilitate the potential of long-term recovery, has transferred some of the iatrogenic insults of the state hospital (e.g., learned helplessness, hopelessness, and passivity) into community settings. The addiction system, on the other hand, proclaims that addiction is a chronic disorder and that recovery is an enduring process, but continues to deliver an ever-briefer model of acute care with little on-going monitoring, support, or re-intervention services, and with diminishing linkages to indigenous communities of recovery. Both systems share a focus on cyclical episodes of symptom manifestation, clinical stabilization, and (in many mental health programs) an almost exclusive focus on symptom management via medication adherence and cost containment (toward the goal of decreased hospitalizations). Little hope is offered to people when they enter these systems and few people work their way through the pre-determined steps required by the systems for their successful discharge. Many leave treatment prior to graduation or are administratively discharged, recycle through repeated acute care episodes, or, alternatively, establish a foundation for long-term recovery outside of the formal treatment system.[23]

These, and other, shortcomings have given rise over the last decade to increasing calls for substantive reforms of policy and practice—what is referred to as "transformation" by the federal government[24-25]—in both systems of care. This transformation is meant to re-orient the current systems from their focus on acute care, symptom reduction, and maintenance of enduring disability to a focus on promoting long-term recovery and full inclusion of people with mental illnesses and/or addictions in community life. Most readers familiar with the history of addiction treatment will, of course, insist that such a notion of recovery is not a new concept. Being "in recovery" and the vision of full and sustained recovery has long been the guiding vision and goal of peer-based mutual support groups within the addiction community (e.g., Alcoholics Anonymous and its many derivatives). However, this notion has not played as much of a role historically within the addiction service provider community, where concepts of primary treatment and relapse prevention have been more central. Within mental health, the notion of recovery has likewise been around at least since the community support movement of the 1970's, if not before.[26] Only recently with the 1999 *Report on Mental Health* of the U.S. Surgeon General[27] and the 2003 President's New Freedom Commission Report on *Achieving the Promise: Transforming Mental Health Care in America*[24] has this notion moved from the periphery of the field to center stage. Included in the dialogue is an argument regarding the need to transform *all* mental health services in order to re-orient them to the goal of promoting and sustaining long-term recovery and community inclusion.

Leadership of the new recovery advocacy movement within addictions has come from people in recovery themselves, through their involvement with grassroots recovery advocacy organizations, seeking to remove barriers to recovery and to improve the quality of life for those with alcohol and other drug problems or those recovering from them. These advocates are calling for a reconnection between addiction treatment and the larger and more enduring processes of recovery and a reconnection between addiction treatment agencies and indigenous recovery support structures in local communities.[28] This grassroots movement parallels a similar evolution in mental health, in which people discharged from psychiatric institutions began to congregate in urban areas in the 1970's to advocate for changes in mental health policy and practice. Now having come of age, what has come to be called the Mental Health Consumer/Survivor Movement[29] has been instrumental in lobbying for major legislative

advances (e.g., the Americans with Disabilities Act) and for envisioning the possibility of profound and far-reaching changes in the ways in which services are developed and delivered. Both movements have converged in articulating the need for the same paradigm shift. The shift involves moving beyond studying pathology and providing professionally-directed treatments to learning from the lived experiences of processes of recovery and offering people the opportunities and supports they need to be able to self-manage their conditions over time, while in the process of reclaiming and rebuilding their overall lives.

As a result of these efforts, both fields are being challenged to design and implement "recovery-oriented systems of care." Steps that are being taken toward such a vision are evident in the re-conceptualization of the relationship between treatment and recovery, the growing interest in models of peer-based recovery support services, and a re-emphasis on the importance of nesting and anchoring recovery within natural environments, as well as in calls for a national recovery-focused research agenda. In addition to the clear and unequivocal statements of the President's New Freedom Commission *Report*[24] and the resulting *Federal Action Agenda* for mental health,[25] calls for recovery-oriented transformation are attaining a similar level of visibility in the addictions field. This is evident in the growing body of literature on chronic disease and recovery management approaches,[23, 30-32] the Center for Substance Abuse Treatment's Recovery Community Support Program, the White House initiated Access to Recovery program, as well as state (e.g., Connecticut, Arizona) and local (e.g., Philadelphia) efforts at systemic transformation and innovative pilot projects of private foundations (e.g., Robert Wood Johnson's Paths to Recovery Initiative). The rationale for such a shift is well-defined in a number of recent reports, including the Institute of Medicine's recently released, *Improving the Quality of Health Care for Mental Health and Substance-Use Conditions*.[33]

The integration of mental health and addiction services may be better achieved through the convergence of these two parallel recovery movements in relation to this need for recovery-oriented transformation than it has thus far through previous efforts focused on historical, structural, or disease-related factors. Guided by an alternative vision that focuses on strengths, resilience, and recovery, the mental health and addiction systems could re-organize their services to address the often long-term and complex needs of persons and families living with mental illness and/or addiction and its aftermaths, including people severely disabled by co-occurring disorders. In order to make the case for this approach to integration, a brief introduction to the concept of recovery and its common elements as they have emerged from these two movements follows. Such an introduction is needed because, despite the many reports and policy statements mentioned above, there continues to be considerable ambiguity and lack of clarity about what precisely is meant by recovery. While practitioners and clinical investigators may be assuming that recovery means abstinence, an absence of symptoms, or the amelioration of deficits, advocates and people in recovery themselves may be referring more to having a safe, dignified, and gratifying life in the presence of on-going disability.[34]

Much work thus remains to be done in both mental health and addictions in reconciling these differences and developing a coherent vision of recovery that can prove to be acceptable (as well as useful) to all involved parties. One attempt to achieve such a vision is offered below, albeit in brief. Readers who are interested in learning more about the various views of recovery in more detail are referred to previous publications on this topic.[23, 28, 35-49]

An introduction to recovery and its common elements in mental illness and addiction

Given its multiple and complicated parentage and the diverse constituencies involved, it is not surprising that it has been difficult thus far to reach consensus on any one definition, or on any one list of essential aspects, of the concept of recovery in mental illness or addiction. There appears, however, to be at least one major source of confusion surrounding use of the term *in both* mental health and addiction systems which lends itself to a realistic and ready-made

solution. This confusion stems from a lack of clarity about the respective roles of mental health and/or addiction practitioners and those of people with mental illnesses and/or addictions themselves. For the purposes of this discussion, the following two definitions are offered as having been helpful in distinguishing the process of recovery (in which the person him or herself is engaged) from the provision of recovery-oriented care (in which the practitioner is engaged) within the overall context of behavioral health (i.e., across the mental health/addiction divide).

- *Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community.*
- *Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person's/family's own long-term recovery efforts.*

Rather than mutually exclusive, these two concepts are intended to be complementary, with the eventual goal of a unified vision that can be promoted equally by people in recovery, their loved ones, behavioral health care practitioners, and the community at large. What is most useful about this distinction is that it places the primary responsibility for recovery clearly with the persons affected most directly by the condition: the person/family themselves. As a direct consequence, the emphasis in transforming systems to become recovery-oriented shifts from what the system, its services, and its practitioners need to do to what people with mental illnesses and/or addictions need to do; with services, systems, and practitioners reworking what they provide to support their recipients of care in entering into and pursuing their own recovery journey. Acknowledging that there are many paths to recovery, and that each individual's journey will be unique, behavioral health providers come to view their primary role as enhancing people's access to a range of opportunities (e.g., to use treatment, gain skills, participate in meaningful activities, pursue their own goals) from which they may choose those most useful to them, and then offering the community-based supports that some people will need (e.g., supported housing, job coaching) in order to take advantage of those opportunities.

Given that this concept of recovery derives from peer support and advocacy communities in both addictions and mental health, it is not surprising that the first definition of recovery refers to what people who have these conditions do to manage their mental illness and/or addiction and their residual effects in order to claim or reclaim their lives in the community. Conventional clinical treatments are not excluded from this definition, but come to take their place alongside of the other non-clinical resources and supports that people need in order to recover, such as love, faith, housing, employment, friendship, and the support of the recovery and broader community. In addition to managing behavioral health conditions, this sense of recovery therefore also involves what people do to overcome the effects of being perceived as an addict or a mental patient—including rejection from society, alienation from one's loved ones, poverty and unemployment, substandard housing or homelessness, social isolation, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to regain some degree of control over their own lives. As experiences of discrimination are viewed as traumatic and irreversible, advocates also argue that a return to a pre-existing state of health (as another alternative definition of "recovery") is not only impossible for many people, but also would diminish the gains the person has had to make to overcome the disorder(s) and its effects. Overcoming the scars of discrimination requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illnesses (what is discussed below as *transcendent recovery*).

It should be clear from this discussion that recovery involves much more than a removal of symptoms from an otherwise unchanged life. It also should be clear that recovery-oriented care—that is, care that is oriented to promoting and sustaining this sense of recovery—takes on a much broader scope, and involves a much broader repertoire of interventions and supports,

than conventional disease-based models of acute treatment followed by so-called "aftercare." The majority of recovery processes, like the majority of the person's life, take place outside of acute care or other treatment settings in the community-based contexts in which people pursue their desires to live, love, learn, work, and play.[24] It is in these processes of recovery, and the ways behavioral health services and community supports are needed to support recovery processes that the basic commonalities between mental illness and addiction are to be found.

Recovery and recovery-oriented care as organizing principles for integration

The principles of a common recovery vision begin with the notion that for both disorders, recovery is a personal and individualized process of growth that unfolds along a continuum, with multiple pathways leading to recovery. First-person accounts of people in recovery from mental illness or addiction have described recovery as a transformational process (sudden, unplanned, permanent) and an incremental process (marked retrospectively by multiple stages of recovery), and recovery stories are often filled with elements of both styles of change. Importantly, it also is made clear within these stories that people in recovery are active agents of change in their lives and not passive recipients of care. The stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and discovery of healing resources within and beyond the self. First-person narratives of recovery from addiction and mental illness also reveal the individualized nature of recovery processes, and the existence of diverse religious, spiritual, and secular frameworks of recovery initiation and maintenance. Finally, people in recovery note the role of family and peer support in making a difference in their recovery.

Core aspects of recovery common across the behavioral health spectrum have been distilled from an extensive review of first-person accounts, a review of the existing literature on recovery, and several years of experience in working with recovery communities in both mental health and addiction..[50] These elements are described in Figure 1 below, which depicts dual recovery in a kind of "hopscotch" format, indicating that some aspects coincide or co-exist with other aspects, while some are more easily distinguished on their own. Despite the apparent linearity of this model, recovery itself is not a linear process, as people move freely between and amongst these different elements at different times. Some aspects, however, do appear to precede or be involved in other aspects, as hope seems to involve feeling cared for by others, while incorporating illness seems to require re-defining and accepting self, which appears to be interwoven with discovering or re-inhabiting valued social roles. Where the model in Figure 1 thus falls short of capturing the complex, non-linear, and dynamic interactions involved in processes of recovery, it hopefully makes up for it by offering a few steps forward toward increased clarity with respect to the common elements of these processes.

See Figure 1 here

Examining these common aspects of recovery from addiction and mental illness, it is surprising that the two fields have yet to partner to organize services under a common vision. People living with mental illnesses and/or addictions want to have hope, eliminate or manage their symptoms, increase their capacity to participate in valued social roles and relationships, embrace purpose and meaning in their lives, and make worthwhile contributions to the lives of their communities. With this shared foundation in place, differences that have existed historically between the recovery visions of the mental health and addictions systems could then provide opportunities for synergistic growth in both. For example, the addictions field has had a well-developed concept of full recovery but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but has, until very recently, lacked a viable concept of full recovery.[23] Both fields, on the other hand, have lacked the concept

of “transcendent” recovery—a heightened level of personal and interpersonal functioning achieved as a result of having survived and transcended the limitations imposed by such severe and complex disorders.[41] Integrating, among other features, the concepts of full, partial, and transcendent recovery within the emerging recovery visions of both systems holds promise for promoting a comprehensive, person-centered, approach to behavioral health.

From this common and comprehensive vision of recovery, the most important implications for developing recovery-oriented practices and integrated systems of care can be distilled. At the level of underlying values, recovery-oriented care is based on the recognition that each person must be either the agent of and/or the central participant within his or her own recovery journey, and that all services therefore need to be organized to support the developmental stages of this recovery process. It follows from this core value that services also should instill hope, be person-and family-centered, offer choice, elicit and honor each person’s potential for growth, build on a person’s/family’s strengths and interests, and attend to the overall life, including health and wellness, of a person with mental illness and/or addiction. These values can be operational in all services for people in recovery from mental illness and/or addiction, regardless of the service type (e.g., treatment, peer support, family education, etc.), recognizing that there are many pathways to healing—both inside and outside of the behavioral health system—that people with mental illnesses and/or addictions can take in their recovery.

In addition to the recognition that there are many paths to recovery, there are several guiding principles in developing recovery-oriented practices and systems. The first of these is that both mental illnesses and addictions demonstrate a broad heterogeneity in both population and outcomes, with the result being that recovery looks different for different people. Second is the need to adopt a long-term, longitudinal perspective and to utilize a developmental framework for matching the person’s point in the recovery process to appropriate interventions. Related to this principle is the need to take into account of the impact of the environment on course and outcome, and, as a result, to focus on person-environment fit and interactions. Third is the non-linear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome, and finally are the important roles of family involvement, peer support, and spirituality as supportive of recovery. These values and principles are listed in Table 1 below, along with commonalities between mental health and addiction with respect to historical and societal attitudes, the goals of care, and the role of the person in recovery. Finally, Table 1 begins to describe some of the strategies that can be used to promote recovery and some of the essential ingredients that are to be found in recovery-oriented systems of care.

What becomes clear as one reads down the columns in this list is that when one begins with recovery and then moves into recovery-oriented practices, the areas of commonality far outweigh any salient differences between mental health and addiction. It is not until you reach the very bottom of the table, when the issue of different treatments and clinical approaches for these conditions emerge, that the table needs to be split along the mental health/addiction boundary. The vast majority of these domains, strategies, and ingredients are common across this historical boundary, and provide ample conceptual common ground for the development of integrated systems of behavioral health care.

See Table 1 here

Implications for Behavioral Health Services

While everyone would conceivably gain from such integration, people who are living with co-occurring psychiatric and addiction disorders would be especially well-served in service systems united under this common vision of recovery. Much has been written about the failures of the mental health system and the addiction system to provide people with co-occurring disorders with the long-term services and supports often needed to promote recovery. A shared

vision of recovery would compel both systems to provide outreach to engage people in a process of recovery, motivational interventions to help people develop readiness for change, treatment, and/or rehabilitation, and provision of on-going recovery support services to assist people to reach their recovery and broader life goals. These pre-recovery engagement, recovery initiation, and recovery enhancement supports would be located in communities, in specific environments of need, and be provided by professionals, family members, and people in recovery themselves. With the individual and family becoming the primary focus and locus of care, long-standing divisions between the two fields may be overcome, first conceptually and then, with adequate political will and resources, throughout the other dimensions (e.g., structural, professional) which currently keep them apart. Perhaps in this way the field will be able to take significant steps toward achieving the degree of integration which was first identified as lacking over 25 years ago, and which behavioral health clients so desperately continue to need and deserve.

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Figure 1. A “Hopscotch” Model of the Common Elements of Recovery across Mental Health and Addiction (Davidson, Andres-Hyman, Tondora, Bedregal, Fry & Kirk, 2006)

Figure 1

(return to article)

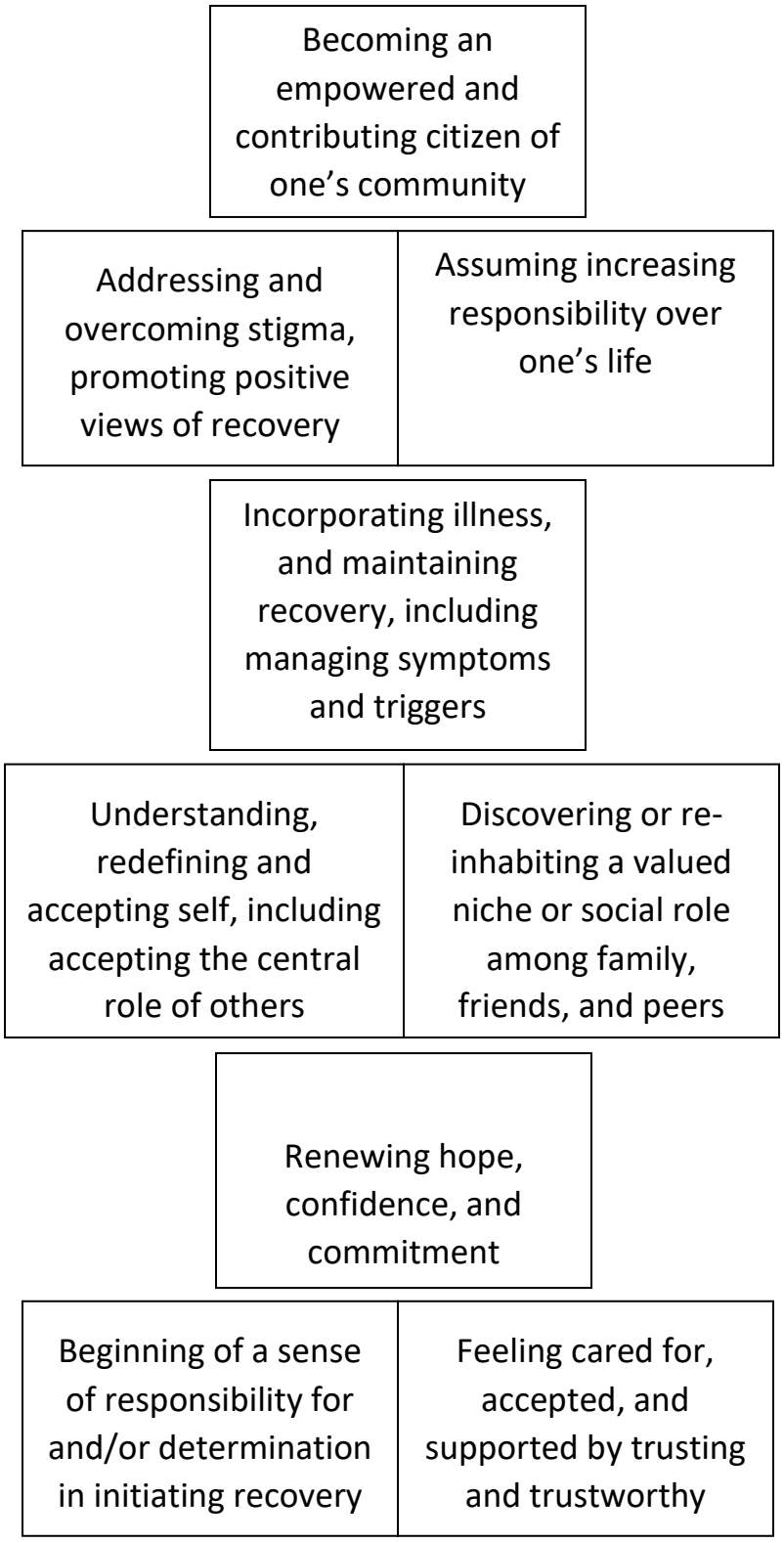

Table 1. Characteristics of Recovery-Oriented Care for Mental Illness and Addiction

Domain	Mental Illness	Addiction
Historical and Societal Attitudes	• Historically, prognosis was often considered hopeless • Debates about cause(s) and nature of illness • Causation theories contributed to harmful interventions, e.g., mandatory sterilization laws • Prejudice and discrimination • Criminalization of illness • Reform movements led by recovering people, families, and visionary professionals	
Goals of Care	• To assist people affected to reduce the interference, impairment, disability, and discrimination associated with the condition(s) and • To support the person's own efforts to manage his or her condition(s) while pursuing a dignified and gratifying life in the community	
Role of the Person with the Condition	• Person must take ownership of his or her own recovery process • Active involvement, including daily decision-making, is necessary for initiating and sustaining recovery • Individual/family involvement, from policy development through service delivery and evaluation	
Underlying Values	• Sustained health care partnership model (versus expert model) • Hope-based • Person- and family-centered • Culturally competent • Trauma informed • Choice philosophy • Promotes growth • Builds on strengths and interests • Focuses on overall life, including wellness, health and spirituality • Recovery-focused outcome measures	
	• There are multiple pathways and styles of recovery • Recovery flourishes in supportive communities • Recovery is enhanced by person-environment fit • Recovery is voluntary • Recovery outcomes vary across heterogeneous population	

Guiding Principles	• Recovery is a longitudinal, developmental process and a continuum • Recovery is non-linear. • Family involvement in recovery is helpful • Peer support in recovery may be crucial • Spirituality may be a critical component of recovery
Strategies to Facilitate Recovery	• Identify and engage early • Carry and instill hope, offer role modeling • Increase motivation for change (recovery priming) • Offer information and education about the condition(s), recovery, available resources, and ways to self-manage the condition(s) • Provide treatments and other interventions that are effective in resolving crises, reducing or eliminating symptoms and/or impairments associated with the condition(s), and improving health • Provide opportunities, rehabilitation, and supports for person to gain needed skills for occupying valued roles (e.g., student, spouse) • Assertively connect person to other people in recovery, mutual support, recovery advocacy organizations, and indigenous recovery communities • Provide post-treatment monitoring (recovery checkups) and support, active recovery coaching (stage-appropriate recovery education and advice), and, when necessary, early re-intervention. • Offer community supports to enable person to lead a self-determined and meaningful life in the communities of his or her choice (e.g., supported housing, supported employment, supported education) • Legal advocacy to counter stigma and discrimination, ensure the person's rights, and enable the person to regain the status of being a contributing member of society

<table>
<tr><td rowspan="5">Essential Ingredients of Recovery-Oriented Systems</td><td colspan="2">Motivation-based outreach and engagement interventions
Basic (material and instrumental) support
Pre-treatment, in-treatment, and post-treatment recovery coaching/ mentoring
Assessment processes that are global, continual, and strengths-based
Respite for people in recovery and families
Rehabilitation and on-going provision of community supports
Peer support
Family education and support
Legal aid/advocacy
Intensive clinical services, including crisis prevention and response, pharmacological and psychosocial treatments, and . . .</td></tr>
<tr><td>Acute inpatient care</td><td>Detox</td></tr>
<tr><td>Illness management and recovery</td><td>Contingency management</td></tr>
<tr><td>Assertive community treatment</td><td>Motivational interviewing</td></tr>
</table>

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Citation: Davidson, L & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *Journal of Behavioral Health Services and Research*, *Journal of Behavioral Health Services and Research*, 34(2), 1094-3412. Posted at www.williamwhitepapers.com

The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services

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Abstract

Despite a range of long-standing historical, political, ideological, professional, structural, and practical barriers, there has been, and continues to be, a clear consensus that integration between mental health and addiction services is sorely needed and long overdue. This paper focuses on one dimension of the challenge of integration from among the several—the conceptual—and proposes the construct of recovery as an organizing principle for bridging the divide between the two domains. After reviewing briefly the parallel history of the two traditions and their shared need for transformation to a recovery orientation, the authors offer an integrated model of recovery for persons with co-occurring disorders. They then derive from this model the underlying values, guiding principles, key strategies, and essential ingredients of recovery-oriented systems of care which comprise a common approach across both addictions and mental illness, offering a strengths-based solution to achieving integration where pathology-focused approaches have failed.

> "Treatment in parallel and separate mental health and substance abuse treatment systems . . . is remarkably ineffective" —Drake and colleagues[1, p. 361]

This conclusion was drawn by Drake and colleagues from their recent review[1] of research on the care of individuals with co-occurring psychiatric and addictive disorders. While the conclusion itself is not surprising, it is striking that this conclusion continues to be just as salient today as it was when it was first reached over 25 years ago.[2-4] Since that time, numerous reports, reviews, and research have documented well and extensively the uneasy relationship that exists between mental health services and services for persons with addictions.[5-16] Consistent epidemiological and service utilization data collected during this same period have shown that mental illnesses and addictions co-occur within the same person as frequently as they exist independently of one another. These data further call into question the current bifurcation of the

behavioral health field into two distinct and heavily bounded territories.[17-18] While work such as the review by Drake and colleagues cited above has sought to overcome this split in the field by repeatedly highlighting the importance of providing integrated care for persons with co-occurring disorders, systemic efforts continue to lag behind and to encounter numerous obstacles. These obstacles range from historical, political, ideological, professional, and fiscal/structural issues at one end of the spectrum (e.g., separate funding streams, independent state agencies) to practical and logistical issues at the other end. And unfortunately, Ridgley, Goldman, and Willenbring's[14] discussion of these obstacles more than 15 years ago remains as relevant today as when first published. Despite these long-standing and formidable barriers, there has been, and continues to be, a clear consensus in the field that integration is both sorely needed and long overdue.

This paper focuses on one dimension of this challenge from among those mentioned above: the conceptual dimension—and this for several reasons. First, previous efforts that have focused on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by these conditions, have failed to establish a common ground adequate to provide a foundation for integration. Efforts aimed at resolving the political, fiscal, and structural issues that impede integration have had minimal impact thus far, perhaps in part due to their lack of a shared conceptual framework on the basis of which a persuasive argument for integration could be mounted. Second, and more importantly, the recent emergence of a "recovery movement" in both mental health and addiction offers a potential new organizing principle for bringing these two worlds together. Persons recovering from these disorders may be offering a pathway to service integration that has thus far remained hidden to behavioral health care policy makers, planners, and managers. Integration has yet to be achieved through a focus on the nature of the disorders or the treatments required to address them; perhaps a focus on the processes of recovery, healing, and community inclusion will. As a core principle of the recovery movement suggests, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction alone have not been able to do.

Prior to making the case for recovery as an organizing principle, this paper provides a brief review of those aspects of the history of mental health and addictions which are shared and also argues that there is an equally pressing need for transformation to recovery-oriented care in both systems. A brief conceptual introduction to the notion of recovery currently being developed and promoted by the recovery movement is then offered and followed by a description of some of the areas of overlap between recovery in serious mental illness and recovery in addiction. With this common ground established, the case is then made for a conceptual integration of mental health and addiction services. The discussion focuses on the essential principles and components of recovery-oriented systems of care—approaches that aim to promote the person's resilience and recovery, and foster community inclusion and support, regardless of the nature of the conditions involved.

The parallel histories of addiction and mental illness and shared need for transformation

The fields of mental health and addiction both have a dark past in which people experiencing mental illnesses and/or addictions endured institutions that offered no treatment, ineffective treatment, or well-intentioned treatment that did harm. Each disorder was considered to be intractable and stories of long-term recovery rarely reached professional or public consciousness. People living with either disorder were expected to end up in the least favorable places in society: the gutter, prisons, asylums, or morgues. Throughout history, both systems of care also have been distracted by debates about the causes and nature of the disorders, troubled by wide-spread prejudice and discrimination, and undermined by the criminalization of behaviors associated with these disorders.[19] Even today, addiction and mental illness occupy a

common space of disgrace in society, and those suffering from these disorders are over-represented within the nation's prisons.[20-22]

At the present time, neither the mental health nor addiction treatment system is focused on supporting long-term recovery. Both systems have failed to acknowledge and overcome the limitations of their traditional institution-based and/or acute care models of treatment and rehabilitation in order to focus on the longitudinal and community-based processes of lasting recovery. Over the past 30 years of hospital closures and downsizing, the mental health system has shifted its focus to support services in the community, but in failing to acknowledge and facilitate the potential of long-term recovery, has transferred some of the iatrogenic insults of the state hospital (e.g., learned helplessness, hopelessness, and passivity) into community settings. The addiction system, on the other hand, proclaims that addiction is a chronic disorder and that recovery is an enduring process, but continues to deliver an ever-briefer model of acute care with little on-going monitoring, support, or re-intervention services, and with diminishing linkages to indigenous communities of recovery. Both systems share a focus on cyclical episodes of symptom manifestation, clinical stabilization, and (in many mental health programs) an almost exclusive focus on symptom management via medication adherence and cost containment (toward the goal of decreased hospitalizations). Little hope is offered to people when they enter these systems and few people work their way through the pre-determined steps required by the systems for their successful discharge. Many leave treatment prior to graduation or are administratively discharged, recycle through repeated acute care episodes, or, alternatively, establish a foundation for long-term recovery outside of the formal treatment system.[23]

These, and other, shortcomings have given rise over the last decade to increasing calls for substantive reforms of policy and practice—what is referred to as "transformation" by the federal government[24-25]—in both systems of care. This transformation is meant to re-orient the current systems from their focus on acute care, symptom reduction, and maintenance of enduring disability to a focus on promoting long-term recovery and full inclusion of people with mental illnesses and/or addictions in community life. Most readers familiar with the history of addiction treatment will, of course, insist that such a notion of recovery is not a new concept. Being "in recovery" and the vision of full and sustained recovery has long been the guiding vision and goal of peer-based mutual support groups within the addiction community (e.g., Alcoholics Anonymous and its many derivatives). However, this notion has not played as much of a role historically within the addiction service provider community, where concepts of primary treatment and relapse prevention have been more central. Within mental health, the notion of recovery has likewise been around at least since the community support movement of the 1970's, if not before.[26] Only recently with the 1999 *Report on Mental Health* of the U.S. Surgeon General[27] and the 2003 President's New Freedom Commission Report on *Achieving the Promise: Transforming Mental Health Care in America*[24] has this notion moved from the periphery of the field to center stage. Included in the dialogue is an argument regarding the need to transform *all* mental health services in order to re-orient them to the goal of promoting and sustaining long-term recovery and community inclusion.

Leadership of the new recovery advocacy movement within addictions has come from people in recovery themselves, through their involvement with grassroots recovery advocacy organizations, seeking to remove barriers to recovery and to improve the quality of life for those with alcohol and other drug problems or those recovering from them. These advocates are calling for a reconnection between addiction treatment and the larger and more enduring processes of recovery and a reconnection between addiction treatment agencies and indigenous recovery support structures in local communities.[28] This grassroots movement parallels a similar evolution in mental health, in which people discharged from psychiatric institutions began to congregate in urban areas in the 1970's to advocate for changes in mental health policy and practice. Now having come of age, what has come to be called the Mental Health Consumer/Survivor Movement[29] has been instrumental in lobbying for major legislative

advances (e.g., the Americans with Disabilities Act) and for envisioning the possibility of profound and far-reaching changes in the ways in which services are developed and delivered. Both movements have converged in articulating the need for the same paradigm shift. The shift involves moving beyond studying pathology and providing professionally-directed treatments to learning from the lived experiences of processes of recovery and offering people the opportunities and supports they need to be able to self-manage their conditions over time, while in the process of reclaiming and rebuilding their overall lives.

As a result of these efforts, both fields are being challenged to design and implement "recovery-oriented systems of care." Steps that are being taken toward such a vision are evident in the re-conceptualization of the relationship between treatment and recovery, the growing interest in models of peer-based recovery support services, and a re-emphasis on the importance of nesting and anchoring recovery within natural environments, as well as in calls for a national recovery-focused research agenda. In addition to the clear and unequivocal statements of the President's New Freedom Commission *Report*[24] and the resulting *Federal Action Agenda* for mental health,[25] calls for recovery-oriented transformation are attaining a similar level of visibility in the addictions field. This is evident in the growing body of literature on chronic disease and recovery management approaches,[23, 30-32] the Center for Substance Abuse Treatment's Recovery Community Support Program, the White House initiated Access to Recovery program, as well as state (e.g., Connecticut, Arizona) and local (e.g., Philadelphia) efforts at systemic transformation and innovative pilot projects of private foundations (e.g., Robert Wood Johnson's Paths to Recovery Initiative). The rationale for such a shift is well-defined in a number of recent reports, including the Institute of Medicine's recently released, *Improving the Quality of Health Care for Mental Health and Substance-Use Conditions*.[33]

The integration of mental health and addiction services may be better achieved through the convergence of these two parallel recovery movements in relation to this need for recovery-oriented transformation than it has thus far through previous efforts focused on historical, structural, or disease-related factors. Guided by an alternative vision that focuses on strengths, resilience, and recovery, the mental health and addiction systems could re-organize their services to address the often long-term and complex needs of persons and families living with mental illness and/or addiction and its aftermaths, including people severely disabled by co-occurring disorders. In order to make the case for this approach to integration, a brief introduction to the concept of recovery and its common elements as they have emerged from these two movements follows. Such an introduction is needed because, despite the many reports and policy statements mentioned above, there continues to be considerable ambiguity and lack of clarity about what precisely is meant by recovery. While practitioners and clinical investigators may be assuming that recovery means abstinence, an absence of symptoms, or the amelioration of deficits, advocates and people in recovery themselves may be referring more to having a safe, dignified, and gratifying life in the presence of on-going disability.[34]

Much work thus remains to be done in both mental health and addictions in reconciling these differences and developing a coherent vision of recovery that can prove to be acceptable (as well as useful) to all involved parties. One attempt to achieve such a vision is offered below, albeit in brief. Readers who are interested in learning more about the various views of recovery in more detail are referred to previous publications on this topic.[23, 28, 35-49]

An introduction to recovery and its common elements in mental illness and addiction

Given its multiple and complicated parentage and the diverse constituencies involved, it is not surprising that it has been difficult thus far to reach consensus on any one definition, or on any one list of essential aspects, of the concept of recovery in mental illness or addiction. There appears, however, to be at least one major source of confusion surrounding use of the term *in both* mental health and addiction systems which lends itself to a realistic and ready-made

solution. This confusion stems from a lack of clarity about the respective roles of mental health and/or addiction practitioners and those of people with mental illnesses and/or addictions themselves. For the purposes of this discussion, the following two definitions are offered as having been helpful in distinguishing the process of recovery (in which the person him or herself is engaged) from the provision of recovery-oriented care (in which the practitioner is engaged) within the overall context of behavioral health (i.e., across the mental health/addiction divide).

- *Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community.*
- *Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person's/family's own long-term recovery efforts.*

Rather than mutually exclusive, these two concepts are intended to be complementary, with the eventual goal of a unified vision that can be promoted equally by people in recovery, their loved ones, behavioral health care practitioners, and the community at large. What is most useful about this distinction is that it places the primary responsibility for recovery clearly with the persons affected most directly by the condition: the person/family themselves. As a direct consequence, the emphasis in transforming systems to become recovery-oriented shifts from what the system, its services, and its practitioners need to do to what people with mental illnesses and/or addictions need to do; with services, systems, and practitioners reworking what they provide to support their recipients of care in entering into and pursuing their own recovery journey. Acknowledging that there are many paths to recovery, and that each individual's journey will be unique, behavioral health providers come to view their primary role as enhancing people's access to a range of opportunities (e.g., to use treatment, gain skills, participate in meaningful activities, pursue their own goals) from which they may choose those most useful to them, and then offering the community-based supports that some people will need (e.g., supported housing, job coaching) in order to take advantage of those opportunities.

Given that this concept of recovery derives from peer support and advocacy communities in both addictions and mental health, it is not surprising that the first definition of recovery refers to what people who have these conditions do to manage their mental illness and/or addiction and their residual effects in order to claim or reclaim their lives in the community. Conventional clinical treatments are not excluded from this definition, but come to take their place alongside of the other non-clinical resources and supports that people need in order to recover, such as love, faith, housing, employment, friendship, and the support of the recovery and broader community. In addition to managing behavioral health conditions, this sense of recovery therefore also involves what people do to overcome the effects of being perceived as an addict or a mental patient—including rejection from society, alienation from one's loved ones, poverty and unemployment, substandard housing or homelessness, social isolation, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to regain some degree of control over their own lives. As experiences of discrimination are viewed as traumatic and irreversible, advocates also argue that a return to a pre-existing state of health (as another alternative definition of "recovery") is not only impossible for many people, but also would diminish the gains the person has had to make to overcome the disorder(s) and its effects. Overcoming the scars of discrimination requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illnesses (what is discussed below as *transcendent recovery*).

It should be clear from this discussion that recovery involves much more than a removal of symptoms from an otherwise unchanged life. It also should be clear that recovery-oriented care—that is, care that is oriented to promoting and sustaining this sense of recovery—takes on a much broader scope, and involves a much broader repertoire of interventions and supports,

than conventional disease-based models of acute treatment followed by so-called "aftercare." The majority of recovery processes, like the majority of the person's life, take place outside of acute care or other treatment settings in the community-based contexts in which people pursue their desires to live, love, learn, work, and play.[24] It is in these processes of recovery, and the ways behavioral health services and community supports are needed to support recovery processes that the basic commonalities between mental illness and addiction are to be found.

Recovery and recovery-oriented care as organizing principles for integration

The principles of a common recovery vision begin with the notion that for both disorders, recovery is a personal and individualized process of growth that unfolds along a continuum, with multiple pathways leading to recovery. First-person accounts of people in recovery from mental illness or addiction have described recovery as a transformational process (sudden, unplanned, permanent) and an incremental process (marked retrospectively by multiple stages of recovery), and recovery stories are often filled with elements of both styles of change. Importantly, it also is made clear within these stories that people in recovery are active agents of change in their lives and not passive recipients of care. The stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and discovery of healing resources within and beyond the self. First-person narratives of recovery from addiction and mental illness also reveal the individualized nature of recovery processes, and the existence of diverse religious, spiritual, and secular frameworks of recovery initiation and maintenance. Finally, people in recovery note the role of family and peer support in making a difference in their recovery.

Core aspects of recovery common across the behavioral health spectrum have been distilled from an extensive review of first-person accounts, a review of the existing literature on recovery, and several years of experience in working with recovery communities in both mental health and addiction..[50] These elements are described in Figure 1 below, which depicts dual recovery in a kind of "hopscotch" format, indicating that some aspects coincide or co-exist with other aspects, while some are more easily distinguished on their own. Despite the apparent linearity of this model, recovery itself is not a linear process, as people move freely between and amongst these different elements at different times. Some aspects, however, do appear to precede or be involved in other aspects, as hope seems to involve feeling cared for by others, while incorporating illness seems to require re-defining and accepting self, which appears to be interwoven with discovering or re-inhabiting valued social roles. Where the model in Figure 1 thus falls short of capturing the complex, non-linear, and dynamic interactions involved in processes of recovery, it hopefully makes up for it by offering a few steps forward toward increased clarity with respect to the common elements of these processes.

See Figure 1 here

Examining these common aspects of recovery from addiction and mental illness, it is surprising that the two fields have yet to partner to organize services under a common vision. People living with mental illnesses and/or addictions want to have hope, eliminate or manage their symptoms, increase their capacity to participate in valued social roles and relationships, embrace purpose and meaning in their lives, and make worthwhile contributions to the lives of their communities. With this shared foundation in place, differences that have existed historically between the recovery visions of the mental health and addictions systems could then provide opportunities for synergistic growth in both. For example, the addictions field has had a well-developed concept of full recovery but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but has, until very recently, lacked a viable concept of full recovery.[23] Both fields, on the other hand, have lacked the concept

of “transcendent” recovery—a heightened level of personal and interpersonal functioning achieved as a result of having survived and transcended the limitations imposed by such severe and complex disorders.[41] Integrating, among other features, the concepts of full, partial, and transcendent recovery within the emerging recovery visions of both systems holds promise for promoting a comprehensive, person-centered, approach to behavioral health.

From this common and comprehensive vision of recovery, the most important implications for developing recovery-oriented practices and integrated systems of care can be distilled. At the level of underlying values, recovery-oriented care is based on the recognition that each person must be either the agent of and/or the central participant within his or her own recovery journey, and that all services therefore need to be organized to support the developmental stages of this recovery process. It follows from this core value that services also should instill hope, be person-and family-centered, offer choice, elicit and honor each person’s potential for growth, build on a person’s/family’s strengths and interests, and attend to the overall life, including health and wellness, of a person with mental illness and/or addiction. These values can be operational in all services for people in recovery from mental illness and/or addiction, regardless of the service type (e.g., treatment, peer support, family education, etc.), recognizing that there are many pathways to healing—both inside and outside of the behavioral health system—that people with mental illnesses and/or addictions can take in their recovery.

In addition to the recognition that there are many paths to recovery, there are several guiding principles in developing recovery-oriented practices and systems. The first of these is that both mental illnesses and addictions demonstrate a broad heterogeneity in both population and outcomes, with the result being that recovery looks different for different people. Second is the need to adopt a long-term, longitudinal perspective and to utilize a developmental framework for matching the person’s point in the recovery process to appropriate interventions. Related to this principle is the need to take into account of the impact of the environment on course and outcome, and, as a result, to focus on person-environment fit and interactions. Third is the non-linear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome, and finally are the important roles of family involvement, peer support, and spirituality as supportive of recovery. These values and principles are listed in Table 1 below, along with commonalities between mental health and addiction with respect to historical and societal attitudes, the goals of care, and the role of the person in recovery. Finally, Table 1 begins to describe some of the strategies that can be used to promote recovery and some of the essential ingredients that are to be found in recovery-oriented systems of care.

What becomes clear as one reads down the columns in this list is that when one begins with recovery and then moves into recovery-oriented practices, the areas of commonality far outweigh any salient differences between mental health and addiction. It is not until you reach the very bottom of the table, when the issue of different treatments and clinical approaches for these conditions emerge, that the table needs to be split along the mental health/addiction boundary. The vast majority of these domains, strategies, and ingredients are common across this historical boundary, and provide ample conceptual common ground for the development of integrated systems of behavioral health care.

See Table 1 here

Implications for Behavioral Health Services

While everyone would conceivably gain from such integration, people who are living with co-occurring psychiatric and addiction disorders would be especially well-served in service systems united under this common vision of recovery. Much has been written about the failures of the mental health system and the addiction system to provide people with co-occurring disorders with the long-term services and supports often needed to promote recovery. A shared

vision of recovery would compel both systems to provide outreach to engage people in a process of recovery, motivational interventions to help people develop readiness for change, treatment, and/or rehabilitation, and provision of on-going recovery support services to assist people to reach their recovery and broader life goals. These pre-recovery engagement, recovery initiation, and recovery enhancement supports would be located in communities, in specific environments of need, and be provided by professionals, family members, and people in recovery themselves. With the individual and family becoming the primary focus and locus of care, long-standing divisions between the two fields may be overcome, first conceptually and then, with adequate political will and resources, throughout the other dimensions (e.g., structural, professional) which currently keep them apart. Perhaps in this way the field will be able to take significant steps toward achieving the degree of integration which was first identified as lacking over 25 years ago, and which behavioral health clients so desperately continue to need and deserve.

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Figure 1. A “Hopscotch” Model of the Common Elements of Recovery across Mental Health and Addiction (Davidson, Andres-Hyman, Tondora, Bedregal, Fry & Kirk, 2006)

Figure 1

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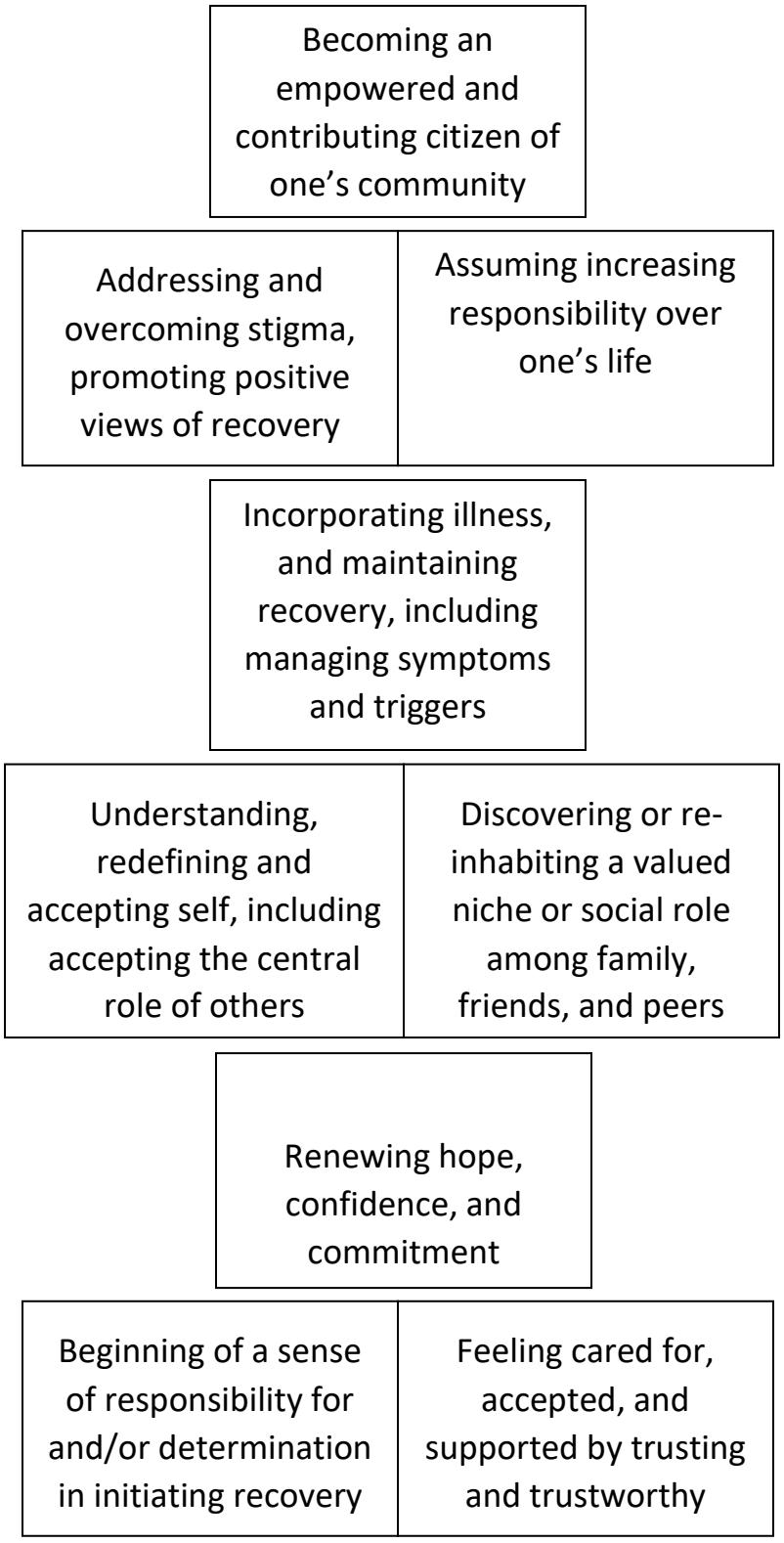

Table 1. Characteristics of Recovery-Oriented Care for Mental Illness and Addiction

Domain	Mental Illness	Addiction
Historical and Societal Attitudes	• Historically, prognosis was often considered hopeless • Debates about cause(s) and nature of illness • Causation theories contributed to harmful interventions, e.g., mandatory sterilization laws • Prejudice and discrimination • Criminalization of illness • Reform movements led by recovering people, families, and visionary professionals	
Goals of Care	• To assist people affected to reduce the interference, impairment, disability, and discrimination associated with the condition(s) and • To support the person's own efforts to manage his or her condition(s) while pursuing a dignified and gratifying life in the community	
Role of the Person with the Condition	• Person must take ownership of his or her own recovery process • Active involvement, including daily decision-making, is necessary for initiating and sustaining recovery • Individual/family involvement, from policy development through service delivery and evaluation	
Underlying Values	• Sustained health care partnership model (versus expert model) • Hope-based • Person- and family-centered • Culturally competent • Trauma informed • Choice philosophy • Promotes growth • Builds on strengths and interests • Focuses on overall life, including wellness, health and spirituality • Recovery-focused outcome measures	
	• There are multiple pathways and styles of recovery • Recovery flourishes in supportive communities • Recovery is enhanced by person-environment fit • Recovery is voluntary • Recovery outcomes vary across heterogeneous population	

Guiding Principles	• Recovery is a longitudinal, developmental process and a continuum • Recovery is non-linear. • Family involvement in recovery is helpful • Peer support in recovery may be crucial • Spirituality may be a critical component of recovery
Strategies to Facilitate Recovery	• Identify and engage early • Carry and instill hope, offer role modeling • Increase motivation for change (recovery priming) • Offer information and education about the condition(s), recovery, available resources, and ways to self-manage the condition(s) • Provide treatments and other interventions that are effective in resolving crises, reducing or eliminating symptoms and/or impairments associated with the condition(s), and improving health • Provide opportunities, rehabilitation, and supports for person to gain needed skills for occupying valued roles (e.g., student, spouse) • Assertively connect person to other people in recovery, mutual support, recovery advocacy organizations, and indigenous recovery communities • Provide post-treatment monitoring (recovery checkups) and support, active recovery coaching (stage-appropriate recovery education and advice), and, when necessary, early re-intervention. • Offer community supports to enable person to lead a self-determined and meaningful life in the communities of his or her choice (e.g., supported housing, supported employment, supported education) • Legal advocacy to counter stigma and discrimination, ensure the person's rights, and enable the person to regain the status of being a contributing member of society

<table>
<tr><td rowspan="5">Essential Ingredients of Recovery-Oriented Systems</td><td colspan="2">Motivation-based outreach and engagement interventions
Basic (material and instrumental) support
Pre-treatment, in-treatment, and post-treatment recovery coaching/ mentoring
Assessment processes that are global, continual, and strengths-based
Respite for people in recovery and families
Rehabilitation and on-going provision of community supports
Peer support
Family education and support
Legal aid/advocacy
Intensive clinical services, including crisis prevention and response, pharmacological and psychosocial treatments, and . . .</td></tr>
<tr><td>Acute inpatient care</td><td>Detox</td></tr>
<tr><td>Illness management and recovery</td><td>Contingency management</td></tr>
<tr><td>Assertive community treatment</td><td>Motivational interviewing</td></tr>
</table>

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Citation: White, W. & Davidson, L. (2006). System Transformation. Recovery: The bridge to integration? (Part 1) *Behavioral Healthcare*, 26(11), 22-25. White, W. & Davidson, L. (2006). System transformation (Part 2) Recovery: The bridge to integration? *Behavioral Healthcare Tomorrow*, 26(12), 24-26. Posted at **www.williamwhitepapers.com**

Recovery:
A Conceptual Bridge between the Mental Health and Addictions Fields

By William White, MA and Larry Davidson, PhD

During the late nineteenth century, conflict flourished between leaders of the Association of Medical Superintendents for American Institutions for the Insane (AMSAII) and leaders of the American Association for the Study and Cure of Inebriety (AASCI). Members of both groups represented institutions and practitioners plagued by the confluence of addiction and mental illness. Chicken or egg arguments on the relationship between the two disorders abounded, as did debates about cultural/ professional ownership of the most intractable clients and their appropriate diagnosis and treatment (Deutsch, 1937; White, 1998). From this inauspicious beginning, an uneasy relationship between the addictions and mental health fields has evolved, marred by sustained conflict, competition, mutual antipathy, and failed service integration efforts followed by re-segregation of the fields. Pockets of successful behavioral health service integration at the local level within this history have been obscured by the overall bifurcation of behavioral health into separate addictions and mental health fields.

A recovery revolution is now occurring within and across the addictions and mental illness problem arenas that challenge practices within both of these fields as well as their historical segregation. This paradigmatic shift will fuel debate over whether this recovery revolution is a long-awaited and desperately needed opportunity to revitalize, or a cataclysm that will de-professionalize and then destroy, both fields. The purpose of this brief essay is to explore whether the concept of recovery could serve as a conceptual bridge through which the treatment of addiction and mental illness could be integrated within one recovery-oriented system of care. The authors speak as long-tenured insiders within these respective fields whose writings and presentations advocate embracing this revolution in thinking and practice (e.g., White, Boyle & Loveland, 2004; White, 2005; White, 2006; Davidson, O'Connell, Tondora, Staeheli & Evans, 2005; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Davidson, Stayner, Nickou, Stryon, Rowe & Chinman, 2001; Davidson & Strauss, 1992, 1995).

Service Integration: Inhibiting and Promoting Forces

A review of the histories of the addictions and mental health fields provides three clues on why past service integration efforts may have failed. First, efforts to integrate the treatments of addiction and mental illness have failed when they focused on discussions of the etiology or nature of these disorders or on treatment philosophies and techniques. Historically, common ground for behavioral health integration does not lie in these arenas, although advances in neurobiology may yet establish such common ground. Second, practitioners from both the addictions and mental health fields have been unprepared and often unwilling to treat clients from their sister field. The relationships between addiction treatment providers and clients with severe mental illness and the relationships between mental health service providers and those with severe alcohol and other drug problems both have been characterized by institutionalized counter-transference (e.g., lack of empathy, disrespect, contempt, exclusion, and extrusion). Service integration efforts have often failed to address these attitudinal barriers. Third, the historical conflict that has pervaded the relationship between theses two fields is imbedded in prolonged competition for scarce resources, fears regarding the loss of institutional and professional legitimacy and integrity, and structural issues at the national level that drive segregated policies, funding streams, and regulatory oversight. Without a strong and shared conceptual foundation, the processes involved in service integration experiments have occurred largely by administration fiat and were often experienced at the front lines as one field attempting to colonize the resources of the other.

What is surprising in light of this history is the continued discussion regarding the potential advantages of an integrated behavioral health system. The forces pushing integration appear to be just as significant as those inhibiting it. People experiencing addictions and those with severe mental illness have often been considered hopeless and been the target of intense social stigma manifested in their sequestration in almshouses, decaying asylums, jails, and prisons, or abandoned on the nation's streets. There is in this shared history a sense that the fate of individuals and families impacted by mental illness and addiction may be somehow linked, and that joint efforts might lead to more progress than isolated efforts.

Adding to the weight of this history is the growing confluence of these problems. Epidemiological and service utilization data reveal that these problems are as likely to co-occur in the same individuals and families as to exist independently of one another. Over the past two decades, an extensive body of literature has illuminated the poor quality of care individuals and families with multiple problems receive within the current system of categorically segregated services. That body of research is confirming the superior outcomes achieved within integrated models of care. All of these factors add momentum to service integration initiatives, but we suspect the primary spark for such integration will come from another source. The individuals and families experiencing these problems and the lived solutions they are discovering suggest new rationales and strategies for service integration that have hitherto escaped policy makers, managers, and practitioners.

The Recovery Revolution

There is a shift within the broad arena of behavioral health from pathology and treatment paradigms to one of recovery (White, 2005). This shift is indicated by:

- The growth and diversification of recovery mutual aid structures (support groups, clubhouses, recovery support centers, recovery housing, recovery educational programs, recovery job co-ops)
- The growth in grassroots recovery advocacy organizations in both fields that are addressing the problem of co-

occurring disorders at both clinical and organizational levels,

- Major policy reports, including the President's New Freedom Commission Report on *Achieving the Promise (2003)*, SAMHSA's *Transforming Mental Health Care in America* (2005), and the National Institute of Medicine's *Improving the Quality of Health Care for Mental and Substance-use Conditions (2006)*.
- New pilot initiatives at the Federal level (CSAT's Recovery Community Support Program and Access To Recovery), and state- and city-initiatives (e.g., CT, Philadelphia) to integrate behavioral health care within a recovery-focused system transformation, and
- Significant increases in number and quality of scientific studies on the pathways and processes of long-term recovery from addiction and from mental illness.

"Recovery-oriented system transformation" is becoming an umbrella concept for integrating behavioral health care and creating systems of care that are culturally competent, trauma-informed, evidence-based, inclusive of families, based on strengths, and connected to communities (as indigenous sources of recovery support). Leading the call for such system transformation are new recovery advocacy movements in both the addictions and mental health fields. These movements, led by people in recovery, their families and visionary professionals, are demanding that care be focused on the processes of long-term recovery and anchored within natural supports and local communities.

Core Ideas

Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction tap resources within and beyond the self to move beyond experiencing these disorders to actively managing the disorders, managing their residual effects and building full, meaningful lives in the community. Recovery is more than the elimination of symptoms from an otherwise unchanged life; it is about regaining wholeness, connection to community, and a purpose-filled life. There are a number of over-arching ideas that are at the core of these new recovery advocacy movements.

1. Recovery is a reality in the lives of millions of individuals and families.
2. There are many pathways and styles of recovery.
3. Recovery is a voluntary process.
4. Recovery flourishes in supportive communities.
5. Recovery gives back (to individuals, families, and communities) what addiction and mental illness have taken away.
6. Behavioral health care must move beyond emergency and palliative care to care that is oriented to promoting long-term recovery.

Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in long-term support of the person's/family's own recovery efforts. Recovery-oriented care shifts the design of the addiction treatment system from an acute care model focused on serial episodes of biopsychosocial stabilization to a model of sustained recovery management. That same recovery orientation in the mental health field shifts the service design beyond cyclical crisis intervention and "sustaining care" aimed at symptom suppression and reduced hospitalizations to one of recovery enhancement. Recovery-oriented care focuses on the acquisition and maintenance of recovery capital (internal and external assets required for recovery initiation and self-maintenance), global health (physical, emotional, relational, and spiritual) and community integration (meaningful roles, relationships, and activities).

Understanding that system change, like recovery, must be led by people with lived experiences of recovery, the

Connecticut Department of Mental Health and Addiction Services consulted with statewide recovery advocacy organizations to develop a set of core recovery values (e.g., self-sufficiency, dignity, respect) and principles to drive their system transformation process. These principles included the following admonitions: 1) f*ocus on people rather than services,* 2) m*onitor outcomes rather than procedural performance,* 3) e*mphasize strengths rather than deficits or dysfunction,* 4) e*ducate the public to combat stigma,* 5) *foster collaboration as an alternative to coercion, and 6*) p*romote autonomy and decrease reliance on professionals* (Recovery Resource Guide, 2002).

Transforming Practices

As we have watched and helped facilitate these experiments in system transformation in states like Connecticut and cities like Philadelphia, we have been struck by the broad changes in practices in both mental health and addiction agencies that unfold as an outcome of recovery-focused system change. Some of the most profound of these changes occur in the following areas (White, Boyle & Loveland, 2002):

- Roles of clients, families, and recovery advocates: Shifts from viewing people with mental illnesses or addictions as the problems a system has to deal with to viewing people in recovery as valuable assets and partners, with their involvement at all levels of service organization and across major functions (policy development, planning, service delivery, service evaluation) in advisory, volunteer, and paid roles; decision-making viewed as crucial to long-term recovery; and a philosophy of choice guides all levels of care and nuanced across developmental stages of recovery.
- Identification, engagement, and retention: Assertive outreach programs, shift from pain-based to hope-based intervention strategies, lowered thresholds of admission, increased use of case management to resolve obstacles to participation, and use of motivational enhancement and contingency management to lower number of clients disengaging from service against medical advice or being administratively discharged.
- Assessment: Shifts from assessment protocols that are categorical (specialized), pathology-based, individual-focused, and an intake function to assessment protocols that are global, strengths-based, family-centered, and continual.
- Service Goals: Symptom reduction/remission shifts from a goal to a strategy; goals focus on quality of life, achievement of personal aspirations, meaningful participation in and service to the community.
- Service planning and service team: Rapid transition from professionally-directed treatment plans to client-driven recovery plans; move to multi-agency, interdisciplinary service models; inclusion of family and indigenous healers (clergy, folk healers, recovery peers, e.g., sponsor) in treatment and recovery planning process.
- Role of the Community: Emphasis on local recovery education and policy advocacy; shift from viewing community as context for or precipitant of relapse to reservoir of resources, hospitality, and support; focus on collaboration with existing recovery support resources and community development strategies to expand the scope and quality of such resources.
- Service Timing: Shifts from crisis-based contact to long-term support focused on critical windows of peak functioning (to acknowledge and celebrate recovery) and critical windows of vulnerability (to provide support through situations that pose risk of relapse); use of regular recovery checkups.

- Locus of Service Delivery: Shifts from institutional environments to client's natural environment; considerable focus on the "ecology of recovery" (helping clients create a recovery-conducive physical and social environment).
- Service Relationship: Shifts from an expert model of diagnosis and treatment to a sustained heath care partnership; shifts from relationship that is hierarchical, transient, and highly commercialized to one that is less hierarchical, sustained, and natural; increased use of peer-based models of recovery support.
- Service Evaluation: Significantly involves clients, family members, and community elders in the evaluation process; emphasis shifts from pathology measures to key recovery indicators; shift from evaluating discrete service episodes to evaluating impact of service combinations and sequences on person's overall life over time.

Toward a Recovery-Oriented, Integrated System of Care

A move toward a more recovery-oriented system of care can occur concurrently and independently with the addictions and mental health fields or it can be used as an opportunity to move towards an integrated system of behavioral health care. We have been frankly surprised at the amount of common ground that is being discovered as recovery advocates from both fields have come to know each other and share their respective stories and concerns. In working with those systems that are attempting behavioral health integration, we have been similarly struck by the discovery that the greatest obstacles to integration are coming at structural levels (the segregation of policy development, service planning, funding, documentation requirements, and regulatory monitoring) and not at the front-line service levels. It is tragically ironic that the infrastructures put in place separately within both fields with a vision of enhancing quality of care now constitute obstacles in achieving that goal.

The structural obstacles to behavioral health care integration are substantial, and only sustained advocacy and new organizing constructs are likely to overcome these obstacles. The collaboration and growing influence of grassroots mental illness and addiction recovery advocacy groups and their progressive elaboration of the recovery concept may well provide the momentum for service integration and the conceptual bridge between the addictions and mental health fields. There is much potential synergy if this continues to unfold. To cite just one example, the addictions field has had a well-developed concept of full recovery for more than 200 years, but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but has, until very recently, lacked a viable concept of full recovery from severe mental illness. Neither field have had an understanding of "transcendent" recovery—a heightened level of personal and interpersonal functioning achieved as a result of having survived and transcended the limitations imposed by such severe and complex disorders (White & Kurtz, 2005). Both fields have much to gain from a dynamic interplay between these various views of recovery, expanding the range of possibilities available to people living with these conditions.

The mental health and addictions fields have focused their collective energies on the study of pathology based on the assumption that discovering the etiological roots, natures, and courses of these disorders would generate effective treatments. Both fields are making substantial progress in the scientific evaluation of interventions designed to treat these disorders. But both fields are just beginning to build foundational knowledge on the prevalence, pathways, styles, and stages of long-term recovery. We envision a future in which behavioral health care will be designed based on intimate familiarity with and knowledge of the lived solutions to these problems. In that vision, two fields will have

become one, and its primary message to the community will be one of hope for recovery from addiction and from mental illness.

Acknowledgment: Work on this article was supported in part by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

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Citation: White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. Journal of Substance Abuse Treatment, 33, 229-241. Posted at **www.williamwhitepapers.com**

Addiction Recovery: Its Definition and Conceptual Boundaries

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Abstract

The addiction field's failure to achieve consensus on a definition of "recovery" from severe and persistent alcohol and other drug problems undermines clinical research, compromises clinical practice, and muddles the field's communications to service constituents, allied service professionals, the public, and policy makers. This essay discusses ten questions critical to the achievement of such a definition and offers a working definition of recovery that attempts to meet the criteria of precision, inclusiveness, exclusiveness, measurability, acceptability, and simplicity. The key questions explore who has professional and cultural authority to define recovery, the defining ingredients of recovery, the boundaries (scope and depth) of recovery, and temporal benchmarks of recovery (when recovery begins and ends). The process of defining recovery touches on some of the most controversial issues within the addictions field.

Keywords: addiction recovery, remission, recovered, recovering, definition, language

1. Introduction

There is growing evidence that the alcohol and other drug (AOD) problems arena is on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused recovery paradigm. The former rested on the assumption that investigations into the etiology and patterns of AOD problems and studies of the professional treatment of these problems would reveal the ultimate solution to these problems. The recovery paradigm posits that solutions to severe AOD problems have a long history, are currently manifested in the lives of millions of individuals and families, and that the scientific study of these lived solutions could elucidate principles and practices that could

further enhance recovery initiation and maintenance efforts (White, 2005).

The shift towards a recovery paradigm is evident in a number of quarters: the international growth of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004a), a new recovery advocacy movement (White, 2006a), and calls to shift the design of addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002; Dennis, Scott, & Funk, 2003; McKay, 2005; Flaherty, 2006). Such a shift is also evident in state and local efforts to transform addiction treatment into "recovery-oriented systems of care", calls to use recovery as a conceptual bridge to integrate addiction and mental health service systems (White, Boyle, & Loveland, 2004; Davidson & White, in press), and the emergence of recovery as the organizing center of national behavioral health policy recommendations (DHHS, 2003; Institute of Medicine, 2006).

This focus on recovery is occurring without a clear definition of recovery and at a time in which there are calls to re-examine and increase the clarity of the language used to depict alcohol and other drug problems and their resolution (CSAT, 2000; Kelly, 2004; Milgram, 2004). The lack of an accepted definition of *recovery* contributes significantly to the variability of reported outcomes of addiction treatment (Maddux & Desmond, 1986). The term's conceptual fuzziness has also produced contention within recovery mutual aid groups and recovery advocacy organizations over when the state of recovery is achieved, lost, and reacquired (White, 2006a). It is not surprising in the face of such confusion that researchers tend to avoid the term, clinicians and mutual aid advocates use the term but with different meanings, and the public tends to understand recovery as an attempt to resolve, rather than the successful resolution of, AOD problems (Faces and Voices of Recovery Public Survey, 2004). The stigma attached to severe AOD problems will continue unabated until the meaning of recovery is clarified, the prevalence of recovery across cultural communities is confirmed by scientists, and a large cadre of individuals and families in long-term recovery stand to offer themselves as living proof of the transformative power of recovery.

Recovery as an organizing concept poses financial and ideological threats to existing social institutions and professional roles that have been granted cultural authority to manage AOD problems. The recovery paradigm is spawning alternative institutions (e.g., recovery advocacy organizations, peer-based recovery support centers) and roles (e.g., recovery coaches, personal recovery assistants, recovery support specialists) that are challenging treatment institutions and competing with them for status and financial resources (Kirk, 2005). Through this process, the recovery concept risks reification, commodification, commercialization, and over-extension. The innumerable threats to the promises of the recovery paradigm render the task of defining recovery and maintaining the integrity of that definition an extremely important task.

This essay proposes criteria for a viable definition of recovery, makes recommendations related to 10 questions critical to the construction of a definition of recovery, and then offers a working definition of recovery for the field's consideration. The primary goal of the paper is to stimulate discussion on the process that should be used to achieve a clearer definition of *recovery* and such derivative terms as *recovering*, *in recovery*, and *recovered.*

The first challenge in defining recovery is crafting a single definition that can meet four quite distinct uses of the term: 1) recovery as a lived experience by individuals and families, 2) recovery experience as the connecting tissue within communities of recovery, 3) recovery as an outcome that can be measured by scientists and those responsible for monitoring and evaluating behavioral health care systems, and 4) recovery as both an organizing vision/goal and a benchmark of accountability for complex service systems.

Towards those ends, an ideal definition of recovery would meet six criteria: 1) precision (captures the essential nature and elements of the recovery experience), 2) inclusiveness (encompasses diverse recovery experiences, frameworks, and styles), 3) exclusiveness (filters out phenomena lacking essential recovery ingredients), 4) measurability (facilitates self-assessment, professional evaluation, and scientific study), 5) acceptability (to multiple constituents), and 6) simplicity (elegant in its clarity and conciseness).

With those purposes and definitional criteria identified, we will explore 10 questions crucial to the task of generating a working definition of recovery.

2. Who has the authority to define recovery at personal, professional, and cultural levels?

Imposed or self-embraced words that convey one's history, character, or status have immense power to wound or heal, oppress or liberate. At a personal level, a definition of recovery will attract or repel people seeking to resolve AOD problems, provide a benchmark for when this state of recovery is achieved, and convey directly or indirectly what actions are required to sustain this status. A particular definition of recovery, by defining who is and is not in recovery, may also dictate who is seen as socially redeemed and who remains stigmatized, who is hired and who is fired, who remains free and who goes to jail, who remains in a marriage and who is divorced, who retains and who loses custody of their children, and who receives and who is denied government benefits.

Defining recovery also has consequences of great import for those competing institutions and professional roles claiming ownership of AOD problems. Choosing one word over another can shift billions of dollars from one cultural institution to another, e.g., from hospitals to prisons. Medicalized terms such as *recover*, *recovery, convalescence, remission,* and *relapse* convey ownership of severe AOD problems by health care institutions and professionals, just as words such as *redeemed* and *reborn, rehabilitate* or *reform,* and *stop* and *quit* shift problem ownership elsewhere. It is important to recognize that rational arguments for particular definitions of recovery may mask issues of professional prestige, professional careers, institutional profit, and the fate of community economies.

The answer of who has authority to define recovery will vary depending on the question, "define for what purpose?" Given that defining recovery could generate unforeseen and harmful consequences, efforts to define recovery should include broad representation from: 1) individuals and family members in recovery, 2) diverse recovery pathways and styles, 3) diverse ethnic communities, and 4) policy, scientific, and treatment bodies, including leaders of the major institutions that pay for behavioral health care services. The driving force behind current behavioral health system transformation efforts are individuals and families directly impacted by and recovering from severe substance use and psychiatric disorders. They are demanding the right to sit at tables at which decisions are made that affect their lives. Given the impact any definition of recovery could have on their lives, their voices should be prominent within any forum that seeks to define recovery.

There will likely be multiple efforts to define recovery, and complete consensus on a recovery definition between all stakeholders in the AOD problems arena is unlikely. However, it may be possible to assure diverse representation in these efforts and to assure that the most critical questions are addressed within these deliberations. The recommendations contained in the following discussions are intended to stimulate dialogue and debate within such forums.

3. Should the term "recovery" be applied only to the resolution of particular types of AOD problems?

Recovery is a medical term that connotes a return to health following trauma or illness. The boundary of the concept of recovery in the AOD problems arena is

greatly dependent on an understanding of what one is recovering from. Technically, there is no recovery if one has no condition from which to recover. AOD use exists on a continuum from AOD abstinence, non-problematic AOD use, subclinical AOD problems (transient problems not meeting severity or persistence criteria for a substance use disorder), and the two broad diagnostic entities *substance abuse* and *substance dependence*, each of which represents a variable span of severity, complexity, and duration. Any definition of recovery should link this term to a previous clinical state. In a survey of natural cessation of illicit drug use, Cunningham (1999) described people who had ever used an illicit drug in their lifetime but had not used an illicit drug in the past year in terms of "recoveries" and "remissions." Such use of the term *recovery* medicalizes AOD use and transient AOD problems that bear little resemblance to severe and persistent substance use disorders. This has contributed to confusion and controversies about the best strategies for resolving AOD problems.

There is considerable evidence that casual users and persons who naturally resolve AOD problems differ significantly from the mostly dependent users admitted to addiction treatment programs. Comparisons of the characteristics of those who achieve natural recovery in community populations with the characteristics of those entering addiction treatment reveal that the former are distinguished by less personal vulnerability, lower problem severity, less medical/psychiatric co-morbidity, greater family and social supports (Grella & Joshi, 1999; Finney & Moos, 1995; Dawson, 1996; Ross, Lin, & Cunningham, 1999), as well as qualitatively different resolution processes (Tuchfeld, 1981; Biernacki, 1986; Cloud & Granfield, 1994). The term "recovery" is best reserved for those persons who have resolved or are in the process of resolving severe AOD-related problems that meet DSM-IV criteria for "abuse" or "dependence" (APA, 1994). The less medicalized terms, *quit* and *cessation,* more aptly describe the problem-solving processes in cases marked by less severity. The broader term *resolution* embraces both patterns of problem solving.

4. What are the essential, defining ingredients of the recovery experience? (Is recovery a time-limited event or a long-term process?)

Recovery folklore, both within professional treatment and mutual aid circles, is replete with references that recovery is a process, not an event. Such folklore is buttressed by innumerable studies that frame recovery as a stage-dependent, developmental process (See White & Kurtz, 2006b, for a review). However, both historical and contemporary evidence suggest that addiction recovery is sometimes the product of a sudden event that is unplanned, positive, and permanent (Miller & C'de Baca, 2001; White, 2004b). Known in the clinical literature as *quantum change* or *transformational change*, this medium of recovery initiation and consolidation often involves profound religious, spiritual, or secular experiences that radically redefine personal identity and interpersonal relationships and suddenly and completely alter one's prior pattern of AOD use.

An ideal definition of recovery would be broad enough to embrace both incremental and transformative styles of recovery initiation and consolidation. White and Kurtz (2006b) have explored diverse pathways (religious, spiritual, secular) and styles (with and without treatment, with and without medication, with and without mutual aid involvement, differences in relational styles and identity in recovery) of recovery. A definition of recovery should avoid restricting the boundaries of recovery to a particular framework, strategy, or style of recovery.

5. Does recovery from a substance use disorder require complete and enduring abstinence?

Recovery defined as a state of sustained abstinence from a drug or category of drugs to which one previously

met DSM-IV diagnostic criteria for abuse or dependence is implied in treatment outcome studies that report findings in terms of the percentage of treated individuals who had achieved uninterrupted abstinence, or who were abstinent at the time of follow-up. This abstinence focus is reflected in the American Society of Addiction Medicine's description of recovery as "a process of overcoming both physical and psychological dependence on a psychoactive drug with a commitment to abstinence-based sobriety" (Steindler, 1998) and in the centrality of "sobriety" and the use of "sobriety birthdays" in Alcoholics Anonymous and other recovery mutual aid groups. Recovery defined as sustained cessation of AOD use is also the centerpiece of the major anti-stigma messaging campaign of new recovery advocacy organizations (Faces and Voices of Recovery, 2006).

In contrast, addiction researchers often define the resolution of AOD problems in more measured gradations, spanning people who: 1) are completely abstinent, 2) are essentially abstinent (low volume of consumption on rare occasions that result in no measurable problems), 3) continue to use but have shifted from clinical to subclinical patterns of use, 4) meet DSM-IV criteria for abuse or dependence but at lower levels of problem severity, and 5) those whose use and related problems have remained unchanged or have accelerated. Considering a widened span of outcomes raises the question of whether abstinence is a defining element of recovery or one of many strategies for achieving recovery.

If abstinence is a defining element of recovery, then a moderated resolution of AOD problems would by definition not constitute recovery. The problem is that such a definition flies in the face of a growing body of evidence that such moderated outcomes are possible for many people with mild to moderate substance-related problems as well as for a much smaller percentage of people with substance dependence (Miller, 1983; Larimer & Kilmer, 2000; Miller & Muñoz, 2005; Dawson, 1996; Finney & Moos, 1981; Rosenberg, 1993). The moderated resolution of AOD problems seems to be most common among persons with less personal vulnerability (e.g., no family history of AOD problems, later developmental onset of AOD use), lower problem severity, lower rates of co-occurring psychiatric illness, and greater personal and family resources (Granfield & Cloud, 1999; Dawson, 1996; Cunningham, Lin, Ross, & Walsh, 2000). The question for the field is whether the moderated resolution of AOD problems will be embraced within the conceptual rubric of recovery.

Reactions to any such suggestion are likely to be very strong from the field's professional and recovery advocacy constituencies. The source of such resistance is often attributed to Alcoholics Anonymous, but such attribution is erroneously placed. Moderation was a strategy that had not worked for early A.A. members, but they made no effort to deny that option to others.

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason-ill health, falling in love, change of environment, or the warning of a doctor-becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention* (*Alcoholics Anonymous*, 1939, p. 31).

> *If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people!* (*Alcoholics Anonymous,* 1939, p. 42).

A.A. makes no claim that the experience of its members constitutes a universal truth applicable to the broader universe of AOD problems. By distinguishing themselves ("real alcoholics") from problem

drinkers, early A.A. members defined their own recoveries in terms of abstinence because that is what in their experience had been most successful. Ironically, scientists are using the latest research findings to reconfirm A.A's distinction that, in modern language, "Everyone who has AOD problems does not suffer from addiction brain disease" (Erickson, 2006). The point is that the meaning of recovery needs to be broad enough to encompass, or sufficiently precise to distinguish, these levels of problem severity.

Moving from the alcohol to illicit drugs arena presents further challenges. Groups like Narcotics Anonymous have defined recovery in terms of abstinence from drug use, but addiction scientists have generally defined recovery from illicit drug dependence in terms of problem resolution rather than absence of drug use. Simpson and Marsh (1986), for example, defined recovery from opiate addiction in terms of the indicators of "reduction of drug use, criminal involvement and unemployment"–a definition not requiring complete and enduring abstinence. Leukefeld and Tims (1986) similarly define recovery as a state in which "drug abuse and related behavior are no longer problematic in the individual's life" (p. 186).

Defining recovery broadly enough (e.g., the resolution of AOD-related problems rather than the method through which such problems are resolved) would allow measuring levels of outcomes over time and answer questions about the viability of particular problem-resolution strategies for particular populations. In the end, it would be helpful to distinguish moderated resolution (sustained deceleration of AOD use and absence of AOD-related problems following the experience of transient, mild-to-moderate AOD problems) from moderated recovery (sustained deceleration of AOD use and absence of AOD-related problems following the experience of sustained and severe AOD problems, e.g., substance dependence). The phrase *moderated recovery* would be best used to designate those individuals with severe AOD problems who have achieved sustained deceleration of the frequency and intensity of AOD use to subclinical levels.

6. Does recovery require abstinence from, or a deceleration of, <u>all</u> psychoactive drug use?

Defining recovery only in terms of an altered relationship with one or more "primary" drugs to which one previously met DSM-IV criteria for *abuse* or *dependence* ignores the propensity for concurrent or sequential problems with multiple drugs. There are a growing number of people entering mutual aid groups and addiction treatment for whom a "primary drug" defies clear identification. This has led to definitions of recovery as enduring abstinence from all traditionally defined drugs of "abuse" (Milam & Ketchum, 1983). The problem with universally declaring all substitute drug use as destructive is an emerging body of evidence that drug substitution can serve as an effective strategy through which some people ward off acute and post-acute withdrawal during their early search for recovery, e.g., the increased use of alcohol and marijuana during the first year of heroin cessation (Simpson & Marsh, 1986; Waldorf, 1983; Copeland, 1998; Bacchus, Strang, & Watson, 2000). Many recovery stories depict the peeling away of different drugs over time in a process that might be aptly described as *serial recovery* (White & Kurtz, 2006b). Recovery from substance use disorders is best defined in terms of one's total relationship with psychoactive drugs, rather than in reference to a single substance.

Attempts to define recovery inevitably confront the question of nicotine dependence among those seeking recovery from other drug dependencies. (Do we give dispensation for some addictions but not for others, e.g., an alcoholic can be in recovery if he or she continues nicotine addiction but not if he or she continues heroin addiction?) This may well be the most difficult of issues. A recent review of the literature (White, 2006b) reveals that:

1) heavy smoking is highly correlated with the development of other severe substance use disorders,

2) most people (85-95%) admitted to addiction treatment in the United States are dependent upon tobacco,
3) people with alcohol problems exhibit more severe nicotine addiction than do smokers without alcohol problems and are less likely to stop smoking,
4) those with more severe nicotine dependencies have poorer treatment outcomes for the treatment of other drug dependencies,
5) continued smoking following treatment for other drug dependencies increases the risk of relapse, and
6) smoking-related diseases are a major cause of death of people who have successfully recovered from alcoholism and other drug dependencies.

This is likely to be one of the most contentious issues in any effort to define recovery. At a minimum, it may be time to conceive and report recovery outcomes in more nuanced categories that convey these variations in recovery status, e.g., full recovery without secondary drug use, recovery with subclinical secondary drug use, partial recovery marked by drug substitution.

7. Does the use of prescribed psychoactive drugs disqualify one from the status of recovery?

A problem that arises from recovery definitions that preclude the use of any psychoactive drugs involves the issue of prescribed psychoactive drugs, including those prescribed as adjuncts in the treatment of addiction, those prescribed for co-occurring psychiatric disorders, and those prescribed for other medical conditions, e.g., acute or chronic pain. There is a deep anti-medication bias in addiction treatment grounded in the long history of iatrogenic insults resulting from attempts to treat addiction with opium, morphine, cocaine, barbiturates, amphetamines, LSD, and tranquilizers of numerous varieties (White, 1998). This bias has decreased in professional and recovery circles as more people with co-occurring disorders have entered treatment and sought membership in recovery fellowships, and as new drugs have arrived with less potential for harm (Meissen, Powell, Wituk, Girrens, & Artega, 1999; Rychtarik, Connors, Demen, & Stasiewicz, 2000). Breakthroughs in the neurobiology of addiction hold great promise for new pharmacological adjuncts in the treatment of addiction (Dackis & O'Brien, 2005), but stigma continues to be attached to some of the most scientifically grounded, medication-based addiction treatments.

The importance of the definitions of *recovery* and *abstinence* (or *sobriety*) in the context of medication-based treatment is evident in Narcotics Anonymous (NA) policy statements on methadone and other medications. NA guidelines for Hospital and Institution meetings in methadone clinics explicitly advise, "When the subject of methadone comes up, it is important not to judge" (H & I Service Bulletin # 3), but the *NA World Service Board of Trustees Bulletin Regarding Methadone and Other Drug Replacement Programs* (Bulletin # 29, 1996) affirms the right of NA meetings to refuse to allow those using medically-prescribed methadone as "drug replacement therapy" to speak at meetings and refers to such individuals as "under the influence of a drug," "still using," and "not clean". The NA pamphlet *In Times of Illness* (1992) emphasizes alternatives to medications, suggests taking medication only when it is necessary, and leaves the issue of "clean time" under such circumstances as something to be resolved with one's sponsor and Higher Power.

How recovery is defined has consequences, and denying medically- and socially-stabilized methadone patients the status of recovery is a particularly stigmatizing consequence (Murphy & Irwin, 1992). A growing number of professional and recovery advocacy organizations are recognizing the legitimacy and potential effectiveness of medication-assisted recovery (White & Coon, 2003; PRO-ACT, 2006), and new recovery support fellowships such as Methadone Anonymous provide a

supportive, recovery-focused milieu for those using medication as an aid to their recovery efforts.

The influence of prescribed psychoactive drugs on an individual's recovery status is best evaluated, not in terms of its presence, but in terms of the motivations for medication use and its effects. Using this principle, the same dose of the same drug could constitute relapse for one person (the use of 70 milligrams of unprescribed methadone for purposes of intoxication) and a recovery adjunct for another (the use of 70 milligrams of prescribed methadone for metabolic stabilization). Use of the phrase "medication-assisted recovery" would help legitimize the recovery status of people who are using medically-monitored medications such as methadone, buprenorphine, naltrexone, acamprosate, or disulfiram as adjuncts to their recovery processes, but might also risk creating a recovery class structure in which this group would be seen as less than full members of local recovery communities.

8. Is recovery something more than the elimination or deceleration of alcohol and other drug problems from an otherwise unchanged life?

Discussions of recovery that focus exclusively on the presence or absence of AOD use ignore the fact that addiction is often intricately bundled (concurrently and sequentially) with other problems, and that the resolution of addiction is often inseparable from the resolution of problems in which it is nested. Recovery definitions that place recovery within the context of global health (Foster, Peters, & Marshall, 2000; Rudolf & Watts, 2002) view the resolution of AOD problems not as a focal point but as a byproduct of larger personal and interpersonal processes. Such definitions withhold the status of *recovery* from someone who has achieved abstinence but has failed to achieve levels of physical, emotional, relational, and ontological (spirituality, meaning, purpose) health.

Reports of temporary sobriety accompanied by poor emotional health have a long tradition in the clinical literature of addiction treatment. In 1933, two years before the founding of Alcoholics Anonymous (A.A.), Richard Peabody declared: "A man who is on the wagon may be sober physically, but mentally he may be almost as alcohol-minded as if he were drunk" (p. 106). A.A. evolved historically through a narrow definition of recovery ("putting a cork in the bottle") to the development of such concepts as *dry drunk, emotional sobriety,* and *serenity* (Wilson, 1958). The current use of the term *wellbriety* by Native American recovery advocates (Coyhis, 1999; Coyhis & White, 2006) similarly reflects efforts to define recovery as sobriety plus global health or quality of life.

Defining recovery in terms that include personal character raises an important question: Why are changes of character applied to the definition of addiction recovery when no such changes are included in definitions of recovery from other health conditions? Recovery from any disorder is best measured within the precise areas affected by the disorder. Recovery from cancer is not measured in terms of reduced criminality because there is no known nexus between cancer and criminality. In the case of severe substance use disorders, recovery is defined in characterological terms because distortions in character mark the very essence of the addiction experience.

Attempts to define recovery face the challenge of distinguishing the resolution of AOD problems from an otherwise unchanged life from a broader transformation of personal character and identity. Most recovered and recovering people define recovery in terms of the resolution of AOD problems AND the progress toward global health (physical, cognitive, emotional, ontological, relational, educational/occupational, financial, and legal). Congruent with this view, the field could consider using the term *remission* to depict the elimination of problems (persons no longer meeting DSM-IV criteria for abuse or dependence) and the term *recovery* to convey remission plus a broader achievement of global health (CSAT, 2006).

The former would convey what has been removed from one's life; the latter would convey what has been added to one's life.

9. Is recovery an all or none proposition or, as with other health conditions, something that can be achieved in degrees?

Even if the definition of recovery is broadened to address the whole scope of psychoactive drug use and to encompass broader dimensions of global health, we are still left with the question of whether recovery is something that exists as a static state that one has or has not achieved or whether it is something that is best measured in more subtle gradations. There is growing evidence that many severe AOD problems constitute chronic disorders whose full stabilization follows multiple recovery initiation efforts (McLellan et al., 2000; Scott, Foss, & Dennis, 2005; Dennis, Scott, Funk, & Foss, 2005). The concepts of "addiction career" and "treatment career" (Frykholm, 1985; Anglin, Hser, & Grella, 1997; Hser, Anglin, Grella et al., 1997) have been used to conceptualize this prolonged process. It may be helpful to extend these concepts to speak of "recovery career" as the processes and stages that mark the resolution of severe and persistent AOD problems.

In their historical review of how the mental health and addictions fields have viewed recovery, White, Boyle, and Loveland (2004) note that the mental health field has organized its services around the goal of partial recovery, but has, until recently, had no concept of full recovery for those experiencing serious mental illness. In contrast, the addictions field has reified the concept of full recovery (defined historically as complete and sustained abstinence), but has had no legitimized concept of partial recovery. White and Kurtz (2006b) advocate use of the term *partial recovery* to convey two different conditions: 1) a reduced frequency, duration, and intensity of AOD use and reduction of AOD-related personal and social problems; or 2) the achievement of complete and sustained abstinence or stable moderation, but the failure to achieve parallel gains in physical, emotional, ontological, relational, or occupational health.

Partial recovery can constitute a permanent state, a stage preceding full recovery, or a hiatus in AOD problems with eventual reversion to a previous or greater level of problem severity. White and Kurtz (2006b) also note the existence of an *enriched or transcendent state of recovery*—a state of amplified health, performance, and social contribution superior to one's pre-addiction life. This acknowledges that some people achieve a peak level of functioning, not in spite of their addiction and recovery, but from the strength drawn from their survival of addiction and the personal transformations they experience throughout the recovery process.

The term *partial recovery* is best applied to patterns of problem resolution marked by decreases in the frequency, duration, and intensity of AOD use and related problems and an increase in the length and quality of periods of sobriety or decelerated use. While the concept of *partial recovery* is included in the ICD-10 and DSM-IV diagnostic classification schemes (APA, 1994; WHO, 1992), it has yet to be elevated and legitimized in the clinical world of addiction treatment.

11. Must recovery be conscious, voluntary, and self-managed?

For some, addiction is a transient experience—a fleeting involvement that, when replaced by other involvements, leaves no lasting mark on personal identity. For others, addiction and recovery become the defining elements of their lives—become who they are at a most personal level (White & Kurtz, 2006b). The importance of this point to our current discussion is that recovery can be a conscious process or the product of what sociologists call "drift" (Matza, 1964; Waldorf, 1983)—a movement out of addiction that is not marked by conscious planning, self-direction, or alterations in personal identity. Recovery does not have to be conscious. The choice to include or exclude "alcoholic/addict" and

"recovery/recovering" into one's sense of self represents, not a pre-condition for the status of recovery, but stylistic differences among people who have resolved severe AOD problems. The term recovery and its derivatives should be applied in the scientific literature and in public discourse to all patterns of resolution of severe and persistent AOD problems (that previously met DSM-IV criteria for abuse or dependence), including those individuals for whom such resolution did not involve self-identification with the states of addiction and recovery.

A related question is the role of coercion in recovery. Recovery advocacy groups emphasize that external authorities can coerce exposure to mutual aid groups or treatment, but only the volition of the individual can sustain recovery. In their view, there is no such thing as coerced recovery (White, 2006a). Researchers are exhibiting sympathy toward this view by distinguishing voluntary abstinence in the community versus artificially induced abstinence in a controlled setting (Godley, Dennis, Godley, & Funk, 2004). Definitions of recovery are most meaningful when they distinguish volitional change from superficial and transient periods of AOD cessation/deceleration generated by institutionalization, rigorous monitoring by external authorities, or crisis-induced respites from active AOD use. It would be helpful if scientific studies of recovery used categories that convey the degree of volitional intent related to recovery, e.g., reporting follow-up status in terms of degrees of freedom—problem abatement in an institutional environment, problem abatement under rigorous monitoring in the community, recovery in the community without external supervision—and for more extended time periods.

12. What are the temporal benchmarks of recovery?

The practice of celebrating sobriety birthdays in AA and NA suggests that recovery in these fellowships begins at the point of cessation of AOD use. Some researchers (Prochaska, DiClimente, & Norcross, 1992) contend that recovery begins before the cessation of alcohol and other drug use, while others link the beginning of recovery to the point that AOD-related problems diminish or cease. Factors that complicate the process of defining a set point for addiction recovery include the fact that most severe AOD problems last a long time (patterns of chronicity) and ebb and flow over their course (patterns of periodicity) (Maddux & Desmond, 1986). Short-term episodes of voluntary or other-imposed abstinence and treatment can mark a respite rather than a termination of addiction (Simpson & Sells, 1990). In short-term studies, brief or extended interludes of abstinence or asymptomatic use may be mistaken for enduring recovery. This requires distinguishing ebbs in the enduring course of addiction from early stages of long-term recovery from addiction. The phenomena of chronicity and periodicity prompted organizations such as the American Medical Association Committee on Alcoholism and Drug Dependence (1970) and researchers (Bejerot, 1975) to include in their definition of recovery time requirements ranging from three to five years.

One could argue that recovery has both qualitative (What essential elements must be present to declare this state?) and quantitative (How long must these conditions be present before one can be considered recovering or recovered?) dimensions. But one could also argue that dichotomous definitions of recovery (one either is or is not recovered/recovering) fail to capture the fluidity of recovery (something one achieves partially or a state one moves in and out of). There are also the questions: When, if ever, does recovery end? Is it a time-limited event/experience or a never-ending process? Can recovery be completed and rendered in the past tense? These questions are most evident in the debates over the terms *recovered* and *recovering*.

Recovered/recovering are terms used to describe the process of resolving, or the status of having resolved, severe AOD problems. Individuals who have resolved such problems have been referred to as

redeemed (or repentant) drunkard, reformed drunkard, dry drunkard, dry (former) alcoholic, arrested alcoholic, sobriate, ex-addict, ex-problem drinker, and ex-alcoholic. They have been described as sober, on the wagon, drug-free, clean, straight, abstinent, cured, recovered, and recovering (White, 1998). Modern debate has focused on the last two of these terms. While *recovering* conveys the dynamic, developmental process of addiction recovery, *recovered* provides a means of designating those who have achieved stable sobriety and better conveys the real hope for a permanent resolution of alcohol and other drug problems. The period used to designate people recovered from other chronic disorders is usually five years of continuous symptom remission.

Many treatment outcome studies evaluate recovery between 6 and 24 months following admission or discharge from treatment, and the two major diagnostic classification systems define recovery in terms of periods of symptom remission ranging from 1 month ("early remission") to 1 year ("sustained remission") (APA, 1994; WHO, 1992). Defining recovery in terms of such short time periods is challenged by studies suggesting that recovery from severe substance use disorders is not stable (point at which the risk of future lifetime relapse drops below 15%) until after four to five years of sustained abstinence or subclinical use (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, O'Donnel, & De Soto, 1989; Dawson, 1996; Jin, Rourke, Patterson, Taylor, & Grant, 1998).

Persons with severe AOD problems often cycle in and out of problematic use and exhibit short periods of abstinence and subclinical use within the larger course of substance dependence. Both moderated and abstinence-based problem resolution require time periods of symptom remission to determine if they are a sustainable pattern of problem resolution or a brief hiatus in one's addiction career. Short periods of self-imposed abstinence or moderation are not by themselves predictive of long-term problem resolution. This conclusion is confirmed by a recent 16-year follow-up study (Moos & Moos, 2006) noting that 60% of individuals who initially achieved natural recovery (defined as problem remission without the aid of professional treatment or recovery mutual aid groups) later experienced one or more relapses.

The terms "full recovery" and "recovered" are best reserved for those individuals previously meeting DSM-IV criteria for abuse or dependence who have sustained recovery (abstinence or non-problematic use and enhanced global functioning) for a period of 5 or more years. Designation of the status of recovery (partial or full) should be based on the presence of three criteria:

- sustained cessation or reduction in the frequency, quantity, and (high risk) circumstances of AOD use following a sustained period of harmful use or dependence (meeting DSM-IV criteria for abuse or dependence),
- absence of, or a progressive reduction in, the number and intensity of AOD-related problems, and
- evidence of enhanced global (physical, cognitive, emotional, relational, educational/occupational, ontological) health.

The term "recovering" best depicts those persons who are making progress toward the achievement of the three above-noted recovery criteria but who have not yet reached the 5-year benchmark of recovery stability. Mutual aid groups have sometimes used one term (*recovering*) for intra-group communication and another term (*recovered*) for extra-group communications. This practice is intended to meet the psychological needs of group members (reinforcing the need for sustained vigilance and self-development) while conveying a message of hope for permanent recovery to the public and those still experiencing AOD problems (White, 2006a).

13. Defining Recovery: A Proposal

Having defined the criteria for an ideal definition of recovery within the alcohol and other drug problems arena and made recommendations related to key questions related to the construction of such a definition, the following definition is offered for consideration.

> *Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD- related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.*

By beginning the definition with the acknowledgement that recovery is an *experience*, we reinforce that recovery is deeply personal and filtered through other dimensions of self—age, gender, ethnicity, sexual orientation, cultural affiliation, degree of religiosity, and particular life-shaping experiences (e.g., personal or historical trauma). Defining recovery as an *experience* is inclusive of change processes that can be either a climactic, health-inducing event (positive, irrevocable, permanent) or marked by time-sustained improvements in health and functioning. Putting *experience* up front also underscores who is at the center of the recovery process—individuals and families—and not the helping professional. Recovery can be achieved with or without professional treatment or participation in peer-based recovery mutual aid groups, although the potential necessity of treatment and mutual aid participation increases as problem severity and complexity increase and recovery assets decrease (Cunningham, 2000; Granfield & Cloud, 1999).

Acknowledging that recovery is *a process* conveys that resolving severe AOD problems is more than a point-in-time decision and that the achievement of long-term recovery requires sustained effort. Depicting recovery as a process conveys that recovery initiation and recovery maintenance are qualitatively different processes (Snow, Prochaska, & Rossi, 1994; Humphreys, Moos, & Finney, 1995).

Acknowledging recovery as *a sustained status* confirms the ability of recovery to alter personal identity and engender meaning from having survived a potentially life-threatening condition. The phrase also suggests that recovery requires external validation. By analogy, one is not in recovery (or remission) from cancer simply by self-declaration. Recovery from severe AOD problems is a status that must stand the test of external validation based on measurable criteria. It must also stand the test of time. Full recovery from severe AOD problems, like full recovery from other life-threatening chronic problems, cannot be declared until a point of durability has been reached in which the risk for future lifetime relapse has been dramatically reduced. Use of terms such as *full recovery*, *long-term recovery*, and *recovered* convey to people with AOD problems and their families, health and human service providers, and the public the real hope for permanent resolution of severe AOD problems (Faces & Voices of Recovery, 2006). In clinical and scientific arenas, it would be helpful to refer to recovery in temporal categories: early recovery (less than 1 year), continuing recovery (1 year to 5 years), and long-term recovery (more than 5 years).

VIEW FIGURE 1

Including *individuals, families, and communities* in the recovery definition transcends the traditional focus on the individual and affirms the interconnectedness between the individual, the family (defined non-traditionally), and the community. Family recovery can be measured through changes in the family system's boundary permeability, the global health of individual family members, changes in family subsystem relationships

(e.g., adult intimate relationships, parent-child relationships, sibling relationships, relationships with the extended family and kinship network), and key dimensions of family life (e.g., roles, rules, and rituals) (White & Savage, 2005). These radical readjustments of family life can be so traumatizing as to threaten the survival of the family as a system (Brown & Lewis, 1999). This broadened perspective on recovery also embraces the relationship between individual/family health and community health—a relationship very evident in the current Native American Wellbriety Movement. ("In the Red Road to Wellbriety, the individual, family and community are one. To injure one is to injure all; to heal one is to heal all.") (White Bison, 2002). Framing the multidimensional experience of recovery within the context of individual, family, and community is visually illustrated in the placement of personal recovery within the Native American Medicine Wheel (Figure 1).

Limiting the application of recovery to those *impacted by severe alcohol and other drug problems* precludes use of the term *recovery* for those who have experienced less severe and transient AOD problems. This definition would limit application of the term *recovery*, at least in scientific and clinical circles, to the resolution of AOD problems that met DSM-IV criteria for *abuse* or *dependence*. It affirms that lessons learned from those with mild to moderate AOD problems are inapplicable to those with severe and chronic AOD problems.

The phrase *utilize internal and external resources* affirms the existence of secular (White & Nicolaus, 2005), spiritual (Galanter, 1997; Miller, 2003; Cook, 2004; Laudet, Morgen, & White, 2006), and religious frameworks of recovery (White & Whiters, 2005). It affirms that recovery can come from an assertion of self or from a surrender and transcendence of self (White & Nicolaus, 2005). The phrase also acknowledges the role of internal and external assets in the recovery process—assets Granfield and Cloud (1999) have collectively christened *recovery capital*.

Use of the phrase *to voluntarily* precludes externally mandated respites in AOD use from the recovery definition and underscores the role of human volition in the maintenance, if not always the initiation, of radically altered relationships with psychoactive drugs. Its inclusion reflects the recognition that free will is neurologically compromised in addiction and progressively rehabilitated through the recovery process (Smith, 2005).

The phrase *resolve these problems* conveys action and movement over time—thus the frequent recovery metaphors of steps, pathways, and journeys. *Resolve* conveys that some repairs of the wounds to self and others have already been completed while others are likely still underway. It conveys that the person, family, and community are in the process of freeing themselves from problems that have dominated their thoughts, feelings, relationships, and activities. For recovery to occur, certain things must be absent and other things must be present—a measurable accounting of withdrawals and deposits.

The use of *resolve these problems*, rather than behavioral criteria of abstinence from one or more drugs and the absence of references to professional treatment or mutual aid societies, makes AOD problem resolution the most essential ingredient of recovery, rather than a particular method of problem resolution. It is also respectful of the "philosophy of choice" that is gaining greater visibility within the recovery support literature (White & Kurtz, 2006a). *Resolve* means that the destructive pattern of AOD use has been aborted, the problems resulting from such use have been or are being rectified to the extent possible, and the chaos and unpredictability that so often characterize severe AOD problems have diminished or been eliminated. It also suggests that the problems arising from stigma related to this condition are also being actively managed at a personal level.

Substituting one destructive drug relationship for another is, in this definition, not recovery. Eliminating one drug dependency (e.g., alcohol) while retaining an equally life-threatening though less life-disrupting drug dependency (e.g., nicotine) would in this definition be viewed as partial

recovery. The question of medication as an adjunct in one's search for recovery would be judged, not by its presence or absence, but by the motivations for its use and its effects on the resolution process. Three specific questions could be asked to make such a judgment:

1) Does the medication incite or quell what people seeking recovery have personified for more than a century as the "beast," "monster," or "dragon" (cellular craving, addictive thinking and self-talk, and compulsive drug seeking behavior)?
2) Does the medication enhance or inhibit broader dimensions of global health?
3) Does the medication result in an increase or decrease in injuries and costs inflicted on the individual, family, community, and culture?

These questions focus not on the presence of psychoactive drugs or the source of such drugs (prescribed or unprescribed), but on what role these substances play in the resolution or exacerbation of AOD problems.

The phrase *heal the wounds inflicted by AOD- related problems* acknowledges that severe AOD problems are often inextricably bundled with other problems, that recovery outcomes are closely linked to broader personal and social adjustment outcomes and that healing and rebuilding individuals, families, and communities wounded by AOD problems takes time (Miller, 1996).

The phrase *actively manage their continued vulnerability to these problems* conveys that there are, at the moment, no permanent technologies to eliminate future vulnerability to AOD problems for those who have arrested those problems. The implication is that individuals, families, and communities become experts on their own recovery processes and take responsibility for actively managing those recovery processes over time.

The final phrase in our definition, *develop a healthy, productive, and meaningful life,* reflects the near universal belief in recovery support circles (across secular, spiritual and religious groups) that recovery is more than an aborted or radically altered pattern of AOD use. The word *develop* is intended to convey movement forward—a "progress, not perfection" framework of change common in recovery mutual aid groups. Such progress can reflect internal changes (e.g., new knowledge, values, thinking patterns, attitudes, character traits, behaviors, skills, decisions, personal identity) or external changes (rituals of daily living, significant changes in interpersonal relationships—particularly with family and friends—and an altered relationship to community as measured by citizenship and service).

Dictionary definitions of *recovery* convey the process of retrieval—a return to a past state or the process of extracting valuable resources from seemingly unusable sources (Oxford English Dictionary, 2006). Such a definition fits the addiction recovery experience in the sense that something of great value has been drawn from the past addiction experience that potentially transforms those who were once a social problem into a valuable social asset. Recovery can also be depicted as a process of *procovery*, *uncovery,* or *discovery*—a movement into new, unexplored dimensions of one's life.

The phrase *a healthy, productive, and meaningful life* conveys the broad changes that often unfold as a means of achieving recovery or that are received as the benefits of the recovery experience. *Healthy* encompasses improvements in quality of life: physical health, emotional health, and enhancement of one's intimate, family, and social relationships. *Productive* suggests the expectation that the anti-social behaviors often associated with severe AOD problems will be replaced by behaviors that contribute to rather than wound the community. *Meaningful* suggests that the new life of recovery is experienced as

something of personal value—that one's life was saved for some reason. It implies that answers to the question "recover to do what?" are being actively sought.

14. Summary

Concerns about how the resolution of AOD problems are conceptualized and semantically expressed are far more than intellectual games played by addictionologists. The choice of concepts and language shapes the fate of those experiencing AOD problems and exerts a profound influence on institutional economies and professional careers. *Recovery* is resurfacing as an advocacy paradigm for reengineering addiction treatment and addiction-related social policies, but the potential of recovery as an organizing paradigm is limited by the failure to define recovery and stake out its conceptual boundaries. Such definitional and boundary setting tasks have great import for clinical research, clinical practice, recovery mutual aid, recovery advocacy, and, most importantly, for individuals and families impacted by severe AOD problems.

This essay discussed ten key questions critical to establishing an operational definition of recovery and presented a definition for consideration that attempted to meet six criteria: 1) precision, 2) inclusiveness, 3) exclusiveness, 4) measurability, 5) acceptability (to multiple constituents), and 6) simplicity. It is hoped that this essay will stir needed discussion and debate. Our progress in intervening with individuals, families, and communities experiencing AOD problems will depend to a great extent on the clarity of our thinking and the clarity of our language.

Acknowledgement: This paper was prepared for the Betty Ford Institute Consensus Conference, September 18-20, 2006. The author wishes to acknowledge Dr. Tom McLellan and Dr. Ernie Kurtz for suggestions that have been incorporated into this paper. I also wish to acknowledge the Consensus Conference participants whose observations helped sharpen points made in this paper. William Miller's theoretical perspectives on relapse (1996) were very helpful in my explorations of the meaning of recovery.

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Figure 1

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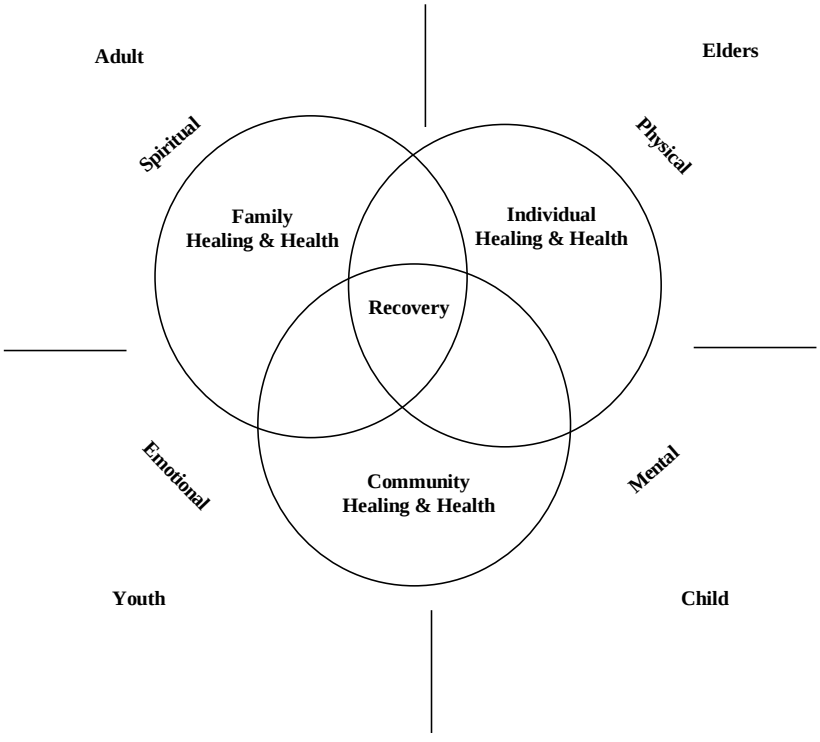

Figure 1: Recovery and the Life Cycle of the Individual, the Family, the Community
Source: Charlene Belleau, Former Chief, Alkali Lake Band of Indians



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Citation: The Net Consumer Council, Evans, A.C., Lamb, R.C., Mendelovich, S., Schultz, C.J. & White, W.L. (2007). The Role of clients in a recovery-oriented system of addiction treatment: The birth and evolution of the NET Consumer Council. Posted at **www.williamwhitepapers.com**

The Role of Clients in a Recovery-oriented System of Addiction Treatment: The Birth and Evolution of the NET Consumer Council

The Net Consumer Council, Arthur C. Evans, PhD., Roland C. Lamb, MA, Sonya Mendelovich, MSW, C. Joseph Schultz, MEd and William L. White, MA

Introduction

A new grassroots recovery advocacy movement and professional efforts to revitalize addiction treatment and improve long-term service outcomes are interacting to spark a radical redesign of addiction treatment in the United States (White, 2006, 2005). What these movements share is a perceived need to extend addiction treatment from a model of brief biopsychosocial stabilization to a model of sustained recovery management. These efforts emulate approaches to the treatment and management of other chronic health care problems, e.g., diabetes, hypertension, and asthma (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Kurtz, & Sanders, 2006; Flaherty, 2006; Dennis & Scott, in press).

The drive to transform addiction treatment into a recovery oriented system of care includes substantial changes in clinical practices, including:

- assertive approaches to early problem identification and engagement,
- streamlined access,
- global, continual, and strength-based assessment protocol,
- a broadened multidisciplinary team that includes a primary care physician and peer-based recovery support specialists,
- integration of evidence-based and culturally indigenous therapies,
- greater use of home- and neighborhood-based services,
- assertive linkage to communities of recovery and other indigenous recovery support resources,
- sustained post-treatment monitoring, support, and, when needed, early re-intervention, and
- a shift in focus from managing and evaluating self-encapsulated service episodes to management and evaluation of the long-term recovery process (White, Boyle, & Loveland, 2002).

Even more fundamental is the altered nature of the service relationship. In the transition from the acute care to the recovery management model, service relationships shift from ones that are hierarchical, professionally-directed, transient, and highly commercialized to relationships that are reciprocal, client-directed, and potentially time sustained. In this latter model, clients are involved at all levels of decision-making within the service system, and the addiction professional shifts from the role of an expert who dictates the service process to an ally and consultant to each client in the long-term recovery process. This "partnership model" will be evident throughout this paper.

This recovery-focused revolution in thinking and clinical practice is reflected in major policy shifts (Clark, 2007), new federal service initiatives (e.g., the Center for Substance Abuse Treatment's Recovery Community Services Program and Access to Recovery program) and within state and local community "system transformation" efforts (Evans & Beigel, 2006; Evans, 2007; Kirk, 2007). Research scientists whose work has focused on behavioral health system performance are similarly calling for "a seismic shift rather than mere tinkering" with the design and delivery of addiction treatment services (Humphreys, 2006).

The purpose of this paper is to review how the recovery-focused systems transformation initiative of the Philadelphia Department of Behavioral Health sparked a local treatment organization, NorthEast Treatment Centers (NET), to develop a client-centered governance and support structure—the NET Consumer Council. Emphasis will be placed on how the NET Consumer Council altered NET's service processes and service outcomes. It is hoped that this article will provide a better understanding of how recovery-focused system transformation efforts are altering how clients experience the process of addiction treatment and recovery.

Behavioral Health System Transformation in Philadelphia

Several key milestones set the stage for dramatic changes in Philadelphia's behavioral healthcare system: the closing of the Philadelphia State Hospital (1990), the creation of Community Behavioral Health (1997) (a private non-profit managed behavioral health care organization) gave the City of Philadelphia direct control over the funds it expends for behavioral health care services, the integration of mental health and addiction services within a newly created Department of Behavioral Health and Mental Retardation Services (DBH/MRS) (2004), and the recruitment of Dr. Arthur Evans (November 2004) to lead the behavioral healthcare systems innovations. DBH/MRS oversees an annual budget of over $1 billion per year for delivery of behavioral health services to more than 100,000 individuals and families in a city with 1.4 million residents.

Philadelphia was ideally poised for a recovery-oriented systems transformation due to mayoral support for behavioral health system transformation, a vibrant network of recovery support groups, a strong recovery advocacy organization, an existing network of more than 85 addiction treatment providers, growing concern about addiction among the local faith community, nationally recognized addiction research capabilities (e.g., the Treatment Research Institute), and the Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services' parallel interest in behavioral health system transformation under the leadership of Estelle Richman.

Key steps in Philadelphia's addiction treatment system transformation efforts include:

- establishment of a Recovery Advisory Committee,
- articulation of a clear vision (create an integrated behavioral health care system for the citizens of Philadelphia that promotes long-term recovery, resiliency, self-determination, and a meaningful life in the community),
- identification of core values that would drive the system transformation process (hope; choice; empowerment; peer culture, support, and leadership; partnership;

community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach),
- a shift in the relationships between service practitioners and service consumers and between DBH/MRS and its local service providers from authority-based relationships to relationships based on mutual respect and collaboration,
- a highly participatory planning process that established a system transformation blueprint,
- the use of training and technical assistance to orient people at all levels of the system to the recovery-focused transformation process, and
- evaluation and ongoing refinement of funding and regulatory policies to eliminate obstacles to system transformation and reward innovation in service design.

As desired changes in service practices were defined through this service transformation process, considerable emphasis was placed on changing the role of the client and altering the nature of the service relationship. More specifically, there were calls to shift toward a philosophy of client choice (rather than professional prescription), greater client/family authority and decision-making within the service relationship, and empowerment of clients/families to self-manage their long-term recovery processes.

An Organizational Transformation Case Study

NorthEast Treatment Centers (NET) has provided a wide continuum of behavioral health services to residents of Southeastern Pennsylvania and Delaware since its emergence as a community-based service organization in 1970. Addiction treatment services include outpatient, intensive outpatient, short-term residential, and long-term residential levels of care and include specialized services for adolescents, women, and persons with co-occurring disorders. In response to the larger systems transformation process sparked by the Philadelphia DBH/MRS, NET embarked on its own systems transformation process in December of 2005.

Following participation in a series of DBH/MRS sponsored training sessions and meetings in 2005, NET leadership committed itself to developing a more recovery-oriented system of care. The first two steps in the NET transformation process included initiating ongoing training of all NET staff on principles of recovery management and restructuring leadership roles, leadership styles, and clinical philosophies. Turf issues had to be overcome, leadership styles modified, and some leadership responsibilities were changed. During the pre-transformation period, each program or service level typically had a Director, Clinical Supervisor, and Care Management Supervisor, with each service unit marked by its own leadership style, clinical philosophy, and service culture. The commitment to recovery management required moving beyond these service silos toward a single integrated philosophy of care and a distinctive service culture that was consumer-driven and recovery oriented.

The process of merging these separate units of operation began with outpatient services in January 2006. Traditional positions were redesigned and/or reclassified. The management team was reorganized to include a Director of Operations, Care Management Director, Clinical Supervisors, Clinical Team Leaders, a Compliance Care Manager, and a Director of Consumer Affairs who subscribed to the same core values pertaining to both leadership and application of a recovery management orientation. A continuum of care was forged with a shared leadership philosophy and a shared recovery culture across all service units and locations. The keys to accomplishing this were having this management team supervise operations of staff at all locations and assigning staff duties that took them to different service locations. NET went from a collection of isolated service programs to an integrated recovery culture in which leaders, staff, and clients could move freely throughout the service culture. In June 2007, the residential treatment programs were assimilated into this approach, thereby completing the reorganization

of staffing and management into one integrated management team.

Seen as a whole, the NET transformation process unfolded in five overlapping steps: 1) re-educating everyone in the NET system toward a recovery management orientation, 2) reorganizing leadership roles and functions, 3) using training and clinical supervision to help staff redefine their roles, 4) merging fragmented and separate program services into an interconnected continuum of care by cross-staffing at all sites and services with a unified team of managers and clinical staff, and 5) creating a consumer council to drive NET's organizational transformation process.

As NET embarked on the development of a consumer-driven integrated system of care, it became clear that NET would be successful in this vision only by developing and promoting a new and dynamic culture of recovery within the organization and the larger community it served. Work toward this vision began with four premises:

1) Service consumers must play a significant role in decision-making at all levels of the organization including the design and delivery of day to day recovery support activities.
2) Long-term recovery is aided by membership and participation in a vibrant culture of recovery in which service consumers have significant roles and responsibilities.
3) A viable culture of recovery must provide continuity of involvement across three stages of personal transformation: pre-treatment engagement; recovery initiation and stabilization, and sustained recovery maintenance (post-treatment monitoring and support and community re-integration).
4) The engine that best drives such a culture of recovery is an integrated consumer-driven system of care (i.e., needs-directed integration of professional services and non-clinical recovery support services across levels of care).

At NET, that culture/community of recovery is defined as a group of responsibly concerned persons in recovery and friends of recovery united to create a spirit of hope and opportunity. The intent of that spirit is sparking and sustaining personal and mutual recovery and contributing to the general welfare of the Philadelphia community. To create this culture of recovery, NET management formulated four guiding directives:

1) A consistent recovery management orientation must be practiced at all levels of care and at all stages of recovery.
2) Evidence-based practices must be applied across levels of care and integrated into a singular, person-centered system of care.
3) The NET culture of recovery must include a wide array of non-clinical recovery supports, e.g., social or peer support programs, faith-based supports, educational and occupational programs, and links to a wide variety of community services and resources.
4) The development of a vibrant NET Consumer Council is the key to sustaining the NET transformation process.

The NET Consumer Council

The NET Consumer Council (CC) was created in August of 2006 to provide representation and support for all service consumers of NET. It grew out of a consumer focus group that envisioned development of a CC that could coordinate a variety of consumer support services. The CC is led by officers who serve 3-month terms who are elected by consumers voting within 14 groups representing the NET continuum of care. Recovering people who are former NET consumers and a NET staff member serve in a volunteer advisory capacity to the CC. The CC created formal bylaws and established four standing committees: 1) the Treatment Committee, which focuses on promoting "responsible concern," coordinating Recovery

Recognition Day, and retaining all members, 2) the Clubhouse Committee, which focuses on the consumer's life outside NET, 3) the Advocacy Board, which addresses consumer feedback, suggestions and grievances, and 4) the Advisory Board, which provides guidance to the CC and is made up of NET alumni, NET staff, and recovery community representatives.

Since its inception, the NET Consumer Council has developed the following core activities.

Consumer Council meetings are held weekly with a 90+% attendance rate of the 14 CC representatives. The meetings are conducted during non-treatment hours and contain such agenda items as planning recovery recognition day and responsible concern projects, volunteer recruitment and training, and recovery support center activity planning.

A monthly Recovery Recognition Day is sponsored by the CC that includes awards for attendance, clean time, and special member contributions. The meetings, which average an attendance of more than 120 consumers and staff, also include quest speakers and a dinner.

Recovery Focus, a bi-monthly consumer council newsletter is distributed to all NET consumers and staff. The newsletter contains recovery-focused articles and a calendar of upcoming meetings and events.

The NET volunteer program mobilizes consumers to regularly (9-12 every Saturday) provide neighborhood clean-up, street outreach, and visits to homeless shelters as well as participation in NET prevention activities for at-risk youth and participation in PRO-ACT's Amends in Action and recovery celebration events.

A Peer Mentor Program assigns consumers to assist with the orientation and coaching of new clients. This includes provision of consumer orientation materials, assignment of a peer mentor to each new consumer, and contact and encouragement by the peer mentor following any missed service appointment.

The Community Living Program (CLP) is a consumer-directed recovery skills program delivered to men residing in the NET Wharton Center, an inpatient residential rehabilitation program. The CLP includes peer-based recovery coaching and community reintegration activities.

The NET Community Recovery Center is a consumer-operated drop-in center that provides social support, emergency housing, treatment referral, medical referral, free clothing, job coaching, and life skills training, and (coming in the new facility) a computer lab. The NET Recovery Center is staffed 80% by consumers and 20% by NET staff. The Center is an entry point into recovery and a way to stay connected to recovery through and following the treatment process.

The Fatherhood Initiative provides linkage to a faith-based program that coaches fathers on reassuming their roles as fathers and husbands.

The Consumer Speakers Bureau allows NET Consumers to share their knowledge about addiction recovery within NET prevention programs and (in planning stage) to businesses, local service clubs, and schools.

Fundraising efforts, such as bake sales, car washes, sale of products developed by consumers (e.g., greeting cards), and solicitation of business donations, are used to support NET Consumer Council Activities.

Core Concepts

The NET Consumer Council is rapidly evolving its own recovery culture filled with recovery-focused ideas, language, symbols, and rituals. The CC is a movement beyond clinical treatment to recovery community building. The recovery community that is emerging under the NET CC is evolving a set of core ideas that infuse its varied activities.

The most central idea within the CC is that of Responsible Concern. This phrase conveys the expectation that all NET consumers will reach out to support each other and give back to the

community. It cultivates the development of citizenship skills and transforms people who have wounded their communities into sources of healing for the community. There are two related concepts. "NETworks!" is a slogan that reinforces the power of mutual support in long-term recovery. This slogan confirms that people in recovery can do together what they failed to achieve on their own. "You are now an ambassador of recovery" is a message conveyed to every new NET consumer. The slogan conveys to each consumer that he or she is now the face and voice of recovery for new members entering this community.

There are also slogans that challenge consumers to take control of their own recovery process. "No Deposit, No Return" conveys that what you get in recovery is commensurate to what you give. The message is: "Your recovery is enriched by helping others with their recovery process." "Walking the Walk" suggests that recovery involves more than "talking a good game." Recovery success is about practicing new recovery skills every day.

A final concept centers on the hope of recovery. "Meaningful recovery is possible—We're living Proof!" signals that both hope and recovery are more than just not "picking up" [using]. It conveys, "In recovery, we can become better people and have new lives."

The Effects of the Consumer Council on NET Clients

In August, 2008, Members of the Consumer Council conducted taped interviews of NET service consumers and asked them what role, if any, participation in the Consumer Council had played in their recovery process. A sampling of their responses conveys the myriad functions the Council is serving.

Empowerment:

- *The Consumer Council empowers the members of the recovering community to take control of their treatment and recovery*.
- *Consumer Council members are empowered by their position and their peers. They become leaders and are perceived as sources of knowledge and access to authority.* (NET Staff Member)

Changing Staff-Client Relationships:

- *The Consumer Council has had a tremendous impact on the NET and the way it sees its consumers. I believe that the staff now know that we are here to concentrate on our recoveries. The consumers have HELPED create a whole new atmosphere at the NET*.
- *I believe that one of the most important tasks of the Consumer Council is to work with the counselors and let them know what's going on with the consumers and to provide a way that consumers can work with the Council towards their treatment.*
- *The most important thing I've learned is communicating with consumers and staff. Here, consumers and staff listen and work together. That promotes the atmosphere necessary for addicts to become active in recovery. The Consumer Council helps bridge communications with staff and consumers and keeps everyone informed of events and activities.*

Creation of Community:

- *It [Consumer Council] has a great effect. It has brought me closer to other addicts like myself—to actually bond and get up there and understand what life is really about.*
- *Being involved with people. I used to isolate and stay to myself. The Consumer Council activities have given me the opportunity to become more involved with people.*
- *I believe that the very first thing we learned, and most important, was how to work together. A lot of different personalities—a lot of friends coming in with their own agenda. We learned how to operate as a team and to take one individual at a time.*
- *Being a part of the Consumer Council has affected my life by giving me a sense of responsibility and making me feel a part of something. The commitments that I have*

taken, helping with Recovery Recognition and being a part of the Consumer Council, all make me feel a part of something important. It keeps me focused on my recovery.

Recognition:

- *I think that the most important task is to get prepared for recognition each month. Recognition allows you to know who is being accounted for—let's you know you're doing something right, achieving something. It gives you great stamina to keep moving forward with your recovery. The most significant part of the Consumer Council is to prepare all the ladies and gentleman for recognition each month.*

Relapse Prevention:

- *The Consumer Council has given me a a better outlook on life—a focus, a better perspective. It helps me cope with problems and to keep me from using.*

Growth:

- *The Consumer Council has made me want to rebuild my will and spiritual growth, as well as personal growth. Since I've been on the Consumer Council I have strived to be a man of responsibility and accountability and I really enjoy helping others. Helping makes me feel good and worthy.*
- *The effect has been tremendous if not profound. Clean-up, Volunteer Services, these allow me to participate in things that were not normal for me. Learning new things causes me to have new ideas and thoughts and actually causes my behavior to change. I'm developing new habits,, like saying thank you and please; respecting others' thoughts. I'm not on the defensive all the time. I'm not thinking about what somebody is trying to get from me all the time. I don't expect everybody to be where I am. I let people be where they are—I try to understand them. I participate in my own recovery. I've done a 180 degree turn, since participation in the NET and the Consumer Council.*

Service:

- *On Wednesday and Friday, I volunteer my services. It keeps me in the same mind of not wanting to use drugs. I'm now a role model to the next addict that still suffers.*
- *The consumer council has had a tremendous effect on my recovery. I'm allowed to help other addicts that need help. When they come to me with their problems, it helps me with the stuff I'm going through*.
- *One of the most needed and crucial parts of recovery is fellowship. Being a part of the Consumer Council lets me work along side others as we rise above our past lives. The activities afford me the opportunity to give back, share and learn. There is nothing better than giving of myself to help others find hope and a better way to live*.
- *First it [Consumer Council] taught me to focus on my own recovery. My main focus now is R.C. (Responsible Concern) for other recovering addicts, myself and the community. To help other people as I was helped coming into this process of recovery.*

Advocacy:

- *The Consumer Council makes sure that things go smoothly and that the consumer is getting the right attention and treatment and trying to get to the goals that they are trying to accomplish*.

Engagement and Continuing Support:

- *The Consumer Council has developed a successful process by which teams of peers welcome and support new consumers, re-engage consumers that are having difficulty, and encourage each other to achieve greater accomplishments. The Consumer Council also serves as a link between treatment and the community at large. They support each other through their transitions and throughout the stages of change. The process reenforces recovery, realistically addresses relapse prevention and continues to support consumers long after they have completed treatment.*

Outreach:

- *I'm in the outreach program and it helps a lot of people that don't have no hope or sense of direction. It reaches out to get them back up on their feet and get them back into society*.

The Effects of the Consumer Council on NET Staff and Program

When NET staff were interviewed about how the NET Consumer Council had effected service outcomes, they consistently noted the following:

1. The new philosophy at NET has established a culture of hope and optimism. It has de-institutionalized and transformed the model of service delivery to one of empowerment. Staff, along with consumers, feel empowered by the spirit of the program.
2. The power struggles that often plagued counselor-client relationships at NET have been reduced almost to the point of elimination. Grievances have declined and expressions of gratitude from clients to staff have increased. The treatment environment feels safer for consumers and staff.
3. Client retention has significantly improved as clients' attitudes shifted from "When will I be done?" to "What do I need to do next to support my recovery?"
4. More clients are committed to a long-term recovery process, which means that more clients are completing a particular level of care and are successfully transitioning to another level of care or to long-term community support systems.
5. Incidents between consumers have declined as consumers have become increasingly vigilant in identifying actions that deviate from recovery-oriented behavior and attitudes. Consumers facilitate quick discussion of potentially problematic situations, defuse tension, and offer encouragement to their peers.
6. Staff are more vested in their jobs, more diligent in the development and implementation of treatment programs, and encouraged to become more creative as a result of consumers' motivation and interest. Staff are energized by the atmosphere, believe their work has value, and thus are more motivated to function at higher levels. Staff experience less resistance, less recidivism, and reduced tension.
7. Consumers free staff time to address clinical issues. Active consumers welcome new individuals seeking treatment, provide initial information, respond to inquiries, and reduce initial client anxieties.
8. Staff are developing a deeper understanding of the recovery process and their role in it.

These benefits accrued after staff had gone through an adjustment to the new NET philosophy. That adjustment was not always easy. Staff sometimes found it difficult to relinquish their perception of absolute authority over consumers. They needed to re-conceptualize their role and develop new models and skills for staff-client relationships. The lack of role clarity early in the transformation process created ambiguity and tension. Professional boundaries became less clear until they were redefined. Participation in the community living program beyond the normal work day was at times burdensome for some staff, and it took some time to realize the value of integrating the community living program into the treatment program. All of these adjustments took time, training, and supervisory support.

Future Plans

The NET has now purchased a building that will be the new home for the Community Recovery Support Center. That facility will provide a platform for the future expansion of NET Council recovery support services. At the present time, Council members would like to work toward the expansion of the Council's role in supporting clients during and following treatment

and in expanding advocacy activities. The latter could include encouraging other community-based recovery support services (e.g., recovery homes) to increase the role of consumers in building community-based recovery cultures. Other plans included expanding community volunteer and advocacy projects; establishing a computer lab, a literacy/GED program, and a job coaching program; fundraising to support Council activities; and providing assistance to other organizations wishing to develop a consumer council and/or a community living program.

Lessons Learned in the Implementation Process

The staff and clients at NET are learning many lessons about how to start a recovery-oriented revolution of ideas and service practices. If we were to offer suggestions based on our experience to date it would be to:

- Create a mission, a vision, and a written plan to guide the organizational transformation process.
- During the pre-implementations stage, educate staff, consumers, and persons providing linked supportive services on recovery management principles. Training should underline key concepts and core values: consumer-driven care, resiliency, self-determination, empowerment, hope, self-respect, respect for others, and responsible concern.
- Demonstrate to staff how much consumers can contribute to a change process
- Use a joint staff, consumer, and community task force to design and implement the new governance process and to redefine roles and responsibilities of both staff and consumers.
- Consider expanding job opportunities for more persons in recovery by reorganizing case aide supports into peer specialists.
- Align yourself with community supports (e.g., housing, peer networks, social services, etc.) who subscribe to a recovery management orientation and where gaps exist, create resources to fill the void, e.g., developing a Recovery Support Center designed and operated by the consumer council.
- Use staff and consumer leadership to constantly promote consumer influence on day-to-day operations and decision making.
- Develop a formal peer mentoring program.
- Involve the Consumer Council in every aspect of organizational decision-making.
- Temper the tendency of Council Members to be harsh on those who do not meet their expectations for participation in Council activities.
- Regularly remind Council Members that Council leadership is not in itself a program of personal recovery and that over-involvement and neglect of personal recovery work can increase one's risk of relapse.
- Orient Council Members who migrate to paid service positions that this new status does not eliminate the need for unpaid service work and their continued accountability to the community that has supported them.
- Recognize that not all staff will master this transition in philosophy and role and that staff will need increased support to make this transition.
- Provide opportunities for consumers to work independently (with minimal supervision) to implement special projects.
- Minimize the potential for Consumer Council representatives to become an exclusive/elitist club by regular leadership rotation.
- Establish standards of proper etiquette that all staff/consumers will be expected to follow, e.g., respectful language, dress, grooming; respect for privacy.
- Support transition from NET consumer leadership to City sponsored peer support

training, recovery advocacy activities, etc.

Summary

NorthEast Treatment Centers (NET) provides a case study of how a recovery-focused system transformation process led by the Philadelphia Department of Behavioral Health and Mental Retardation Services affected the service philosophies and practices of a local addiction treatment organization. The centerpiece of this organizational transformation was the NET Consumer Council through which clients were empowered to shape a vibrant recovery culture. Consumer Councils constitute an important vehicle in transforming traditional addiction treatment institutions into recovery-oriented systems of care. The achievement of that goal requires substantial changes in service philosophies, service roles, and, most importantly, the service relationship.

Acknowledgments: We would like to acknowledge the NET consumers, the NET Consumer Council, and the NET staff for sharing their experience of the DBH/MRS and NET system transformation processes. The NET consumers and staff would like to offer special thanks to Terence McSherry, President and CEO of NET Treatment Services, Inc., whose leadership made the NET system transformation process and the Consumer Council possible.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2007). Language and recovery advocacy: Why we worry about the words. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*. Winter, pp. 1, 3. Posted at **www.williamwhitepapers.com**

Language and the Recovery Advocacy: Why We Worry about Words

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Words are important. If you want to care for something, you call it a "flower"; if you want to kill something, you call it a "weed". --Don Coyhis

Some will question why we as recovery advocates should invest valuable time debating the words used to convey alcohol and drug (AOD) problems and their solutions when there are suffering individuals and families that need to be engaged, recovery support resources that need to be created, communities that need to be educated and regressive, discriminatory policies that need to be changed. We must invest this time because achieving our broader goals depends on our ability to forge a recovery-oriented vocabulary.

Words have immense power to wound or heal. The wrong words shame people with AOD problems and drive them into the shadows of subterranean cultures. The wrong words, by conveying that people are not worthy of recovery and not capable of recovery, fuel self-destruction and prevent or postpone help-seeking. The right words serve as catalysts of personal transformation and offer invitations to citizenship and community service. The right words awaken processes of personal healing, family renewal, and community and cultural revitalization. The wrong words stigmatize and disempower individuals, families and communities.

Words determine the social institutions that will lay claim to AOD problems and whether people with such problems will find themselves in systems of compassion and care or systems of control and punishment. How we as a culture conceptualize AOD problems dictates whether the people with those problems will be tended to by a physician, a counselor, a preacher, a community activist or a jailer. The labels d*runkard*, *dipsomaniac*, *wino*, *dope fiend*, *crack whore*, *speed freak*, and *substance abuser* (to name a few) elicit fear and disdain, whereas mothers, fathers, brothers, sisters, sons, daughters, friends, neighbors, co-workers and employees with AOD problems can lay claim to our

compassion and the resources of our communities.

It is time people in recovery rejected imposed language and laid claim to words that adequately convey the nature of our experience, strength and hope. We must forge a new vocabulary that humanizes AOD problems and widens the doorways of entry into recovery. We must forever banish language that, by objectifying and demonizing addiction, sets the stage sequestration and punishment. We must counter the clinical language that reduces human beings to a diagnostic labels that pigeon-hole our pathologies while ignoring our strengths and resiliencies. We must also reject the disrespectful and demeaning epithets (e.g., “retreads”, “frequent flyers”) professionals sometimes use to castigate those who need repeated treatment episodes.

Historically, people with severe AOD problems have had wars declared against them and been subjected to invasive and unconscionable practices (e.g., laws calling for their mandatory sterilization) because this culture defined them as less than human and depicted them as hopeless through words and phrases (“once an addict, always an addict”).

We need a new language that is hope-infused, recovery-focused, and family-centered. We need a new language that reflects and conveys diverse pathways and styles of recovery. The words and metaphors that permeate White Bison will differ from those that permeate the Recovery Alliance of El Paso or PRO-ACT’s Woman’s Recovery Center in Pennsylvania. We can expand our menu of catalytic words and metaphors at the same time we can formulate a common vocabulary that will best enhance a national message that clearly and passionately conveys the living reality of long-term recovery from addiction.

I urge you to participate in these discussions and debates about language. This is not about superficial political correctness. It is about the future of recovery in America. It is time we embraced a new language that helps us talk about how we heal ourselves, our families and our communities. It is time we abandoned a rhetoric that declares war on our own people.



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Citation: White, W. (2007). Substance abuse versus substance dependence: Implications for management of the DUI offender. Briefing Paper for the Administrative Office of the Illinois Courts and the Illinois Secretary of State. Posted at **www.williamwhitepapers.com**

Substance Abuse vs. Substance Dependence: Implications for the Management of the DUI Offender

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Introduction

Over the past three decades, the author has provided ongoing training to key stakeholders involved in the management of DUI offenders in the State of Illinois. Included among those key stakeholders are traffic court judges, states attorneys, probation officers, court social service workers, DUI evaluators, treatment specialists, and DUI hearing officers. One of the most consistent areas of interest expressed by these professionals is the distinction between substance use and substance dependence and whether placement in one or the other diagnostic category influences risk of DUI recidivism or approaches to management and treatment. The purpose of this paper is to provide answers to such questions that are brief and as clear as current research will allow.

How were the diagnoses of substance abuse and substance dependence developed?

Internationally, there are two major systems for classifying psychiatric illnesses: the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition; DSM-IV) of the American Psychiatric Association and the *International Classification of Diseases* (tenth edition, ICD-10) of the World Health Organization. DSM-IV is the primary system of diagnostic classification used in the United States.

In the first and second editions of DSM published in 1952 and 1968, addiction was classified as a personality disorder—a classification reflecting the view that addiction was not a disease in its own right but a symptom of a disordered personality (Saunders, 2006). In the third edition of DSM published in 1980, substance use disorders were listed as separate disorders under the headings substance abuse and substance dependence. (The term substance dependence won out over the term addiction by one committee member vote)(O'Brien, Volkow, & Li, 2006). In two subsequent revisions—DSM-III-R (1987) and DSM-IV (1994)—the criteria for abuse and

dependence were refined based on the work of Edwards and Gross (1976). In DSM-IV, the criteria for substance abuse reflect a less severe disorder than substance dependence such that one can only be diagnosed with substance abuse in the absence of substance dependence.

Research reviews and expert panels for a planned DSM-V began in 2004 and are expected to be completed in 2012-2014. The ICD will be undergoing revision during this same time period.

What are the differences in criteria for substance abuse versus substance dependence?

The DSM-IV defines the diagnostic criteria for substance abuse as *a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:*

1. *Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).*
2. *Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).*
3. *Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).*
4. *Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).*

The DSM-IV defines substance dependence *as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:*

1. *Tolerance, as defined by either of the following:*
    a. *A need for markedly increased amounts of the substance to achieve intoxication or desired effect.*
    b. *Markedly diminished effect with continued use of the same amount of the substance.*
2. *Withdrawal, as manifested by either of the following:*
    a. *The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for Withdrawal from the specific substances).*
    b. *The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.*
3. *The substance is often taken in larger amounts or over a longer period than was intended.*
4. *There is a persistent desire or unsuccessful efforts to cut down or control substance use.*
5. *A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.*
6. *Important social, occupational, or recreational activities are given up or reduced because of substance use.*
7. *The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).*

DSM-IV includes several specifiers for substance dependence, one of which outlines whether substance dependence is

with physiologic dependence (evidence of tolerance or withdrawal) or without physiologic dependence (no evidence of tolerance or withdrawal). In addition, remission categories are classified into four subtypes: (1) full, (2) early partial, (3) sustained, and (4) sustained partial; on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. The remission category can also be used for patients receiving agonist therapy (such as methadone maintenance) or for those living in a controlled, drug-free environment.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Copyright 1994, American Psychiatric Association. http://www.appi.org

What is the degree of scientific validity of these classifications?

In 2002, a Research Society on Alcoholism meeting was held in San Francisco to specifically discuss this question. The scientists present concluded the following: "The findings support the validity of DSM-IV alcohol dependence across numerous study designs and samples." They went on to suggest that the findings of the studies they reviewed "raised questions about the validity of the diagnosis of alcohol abuse as currently defined" (Hasin, Schuckit, Martin et al., 2003). Studies of diagnostic reliability also note high reliability for substance dependence but greater variability of reliability for substance abuse (Hasin, Hatzenbueler, Keyes, & Ogburn, 2006).

Problems related to this classification include the following:

- Many terms used in the diagnostic criteria (e.g., larger amounts, longer periods, important activities) have not been adequately defined (Harrison, Fulkerson, & Beebe, 1998).
- Surveys reveal that many of those meeting general diagnostic criteria use 3 or more drugs, challenging the application of drug-specific diagnoses (Harrison, Fulkerson, & Beebe, 1998).
- A significant portion of those diagnosed with substance abuse do so by meeting only one symptom, e.g., hazardous driving (Hasin et al., 1997; Hoffman & Hoffman, 2003).
- Symptoms of abuse and dependence are not easily distinguished in some populations, e.g., adolescents (Harrison et al., 1998; Fulkerson et al., 1999).
- There is a social trend to describe all adolescent substance use as "abuse"—further obscuring the diagnostic precision of this term (Harrison, Fulkerson, & Beebe, 1998).
- The frequent report of tolerance among adolescents may be developmentally normal and not "a pathological process indicative of alcohol dependence" (Grant, Compton, Crowley, et al., 2007).
- Fulkerson and colleagues (1999) have argued that there is no clinical value in distinguishing substance abuse and substance dependence in adolescents.
- There is often overlap in some symptoms across the diagnoses of alcohol abuse and alcohol dependence (Grant, Harford, Muthen et al., 2007).
- "The lack of highly sensitive and specific biological tests leaves the need to rely on less precise behaviorally oriented criteria sets" (Hasin et al., 2003).
- The emphasis on tolerance and withdrawal as dependence criteria has led to withholding appropriate medication from pain patients (O'Brien, Volkow, & Li, 2006).
- Addictionologists and recovery advocates have attacked use of the term "abuse" on the grounds that it is pejorative, stigmatizing, and applied to no other health condition (Graham & Schultz, 1998; White, 2006).

Wouldn't everyone with a diagnosis of substance dependence also manifest signs of substance abuse?

While some studies continued to report a migration from substance abuse to substance dependence (Ridenour, Cottler, Compton et al., 2003), general population studies in the US have concluded that "a substantial portion of those with alcohol dependence did not manifest signs of alcohol abuse" (Hasin & Grant, 2004). In the most recent study, one-fifth of those with DSM-IV drug dependence did not meet diagnostic criteria for substance abuse—a pattern more prevalent in women than in men (Hasin, Hatzenbueler, Smith, & Grant, 2005). A recent review of the research on this question was clear:

> *Alcohol abuse and alcohol dependence are conceptually and diagnostically separate and distinct entities. One is not a precursor or predictor of the other.* (Grant, Compton, Crowley et al., 2007).

The clinical importance of this has been summarized as follows:

> *Different biopsychosocial processes may give rise to the symptoms of drug dependence and drug abuse. For example, genes affecting reward, craving withdrawal (characterizing dependence) may differ from genes affecting novelty-seeking or behavioral undercontrol (characterizing abuse*) (Hasin et al., 2005).

The relationship between alcohol abuse and dependence is a somewhat controversial one, with some conflicting reports. Most studies have found that only about 10% of those with alcohol abuse later progress to alcohol dependence (Schuckit, Smith, Danko et al., 2005). The relationship between abuse and dependence may, however, differ by drug of preference. Ridenhour et al. (2003) found a progression from abuse to dependence with alcohol and cannabis, but not for cocaine or opiates.

Do the course of substance abuse and the course of substance dependence differ?

Reviews of the course of abuse versus dependence conclude that "dependence is likely to remain chronic, while abuse is likely to remit and unlikely to progress to dependence" (Hasin, Van Rossem, McCloud, & Endicott, 1997; Hasin et al., 2003; Hasin, Hatzenbueler, Smith, & Grant, 2005; Grant, Harford, Muthen, et al., 2007). A study of the four-year course of alcohol dependence and alcohol abuse revealed that most of those diagnosed with alcohol dependence at baseline remained there four years later. In contrast, two-thirds of those with a substance abuse diagnosis no longer met criteria for that disorder four years later. What distinguished this maturing out from the one-third who remained in the abuse category was not clear from the study. In a five year follow-up study, Schuckit and colleagues (2002) found that a diagnosis of dependence was associated with a 70% greater risk of problem continuation than a diagnosis of substance abuse.

What about people who are referred to as "diagnostic orphans"?

Diagnostic orphans are individuals who meet some criteria for substance dependence but not enough to warrant a diagnosis, e.g., reporting only increased tolerance. This category may also include people who had alcohol or other drug-related problems that have not yet met the diagnostic threshold. Those with subthreshold alcohol problems have represented as much as 20% of the adult population in some surveys (Chung et al., 2002). At present, we know very little about this group. They may reflect people on their way to developing more severe problems, people who are in the process of decelerating alcohol and other drug problems, or persons who have reached and sustained a plateau of less severe problems.

In general, diagnostic orphans have less alcohol problems at five-year follow-up than those who meet criteria for alcohol abuse or alcohol dependence.

Discussion

What conclusions can one draw from the existing scientific studies of alcohol abuse and alcohol dependence and how should these findings influence the decisions of those professionals charged by the community for evaluating, punishing, treating, and monitoring DUI offenders? Based on this author's review of this data and his work in addiction treatment for nearly four decades, the following conclusions are offered as points for discussion.

The lack of objective physical diagnostic tests, the reliance on offender self-report, the variability in the competence of evaluators, and overlap in the diagnostic criteria all compromise the ability to make decisions based solely on a differential diagnosis of alcohol abuse or alcohol dependence. This principle bodes caution in the over-reliance on a diagnosis for risk prediction or for service planning. The rapid breakthroughs that are occurring in the neurobiology of addiction promise new tools (e.g., blood tests) to enhance accuracy of diagnosis.

To the extent that the accuracy of diagnoses can be relied upon, those with a diagnosis of alcohol dependence are likely to be at greater risk of DUI recidivism than those with a diagnosis of alcohol abuse. The reason for this increased risk lies in the greater severity and longer course of alcohol dependence. And yet one would be remiss in assuming that alcohol abuse is a transient problem that will dissipate with personal maturation and social consequences in all persons.

Alcohol abuse and alcohol dependence present at very different levels of severity. The higher the problem severity within each diagnosis, the greater the risk for future DUI recidivism. Problem severity can be measured in two ways: the number of the diagnostic criteria that are met and the frequency and intensity of each criteria met. In the latter, for example, an individual could meet only one criteria for alcohol abuse such as *Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use),* but drive at a high degree of impairment (high BAC) and a a high degree of frequency.

Among the dependent population, the single best predictor of increased risk for future relapse (Chung et al., 2002) and a more severe and prolonged addiction career (Schuckit et al., 2002) is a history of withdrawal symptoms. As it relates to public safety, what evidence of withdrawal predicts is the loss of volitional control over when and under what circumstances one drinks. In the face of acute withdrawal, one's past resolutions not to drink and drive again may mean very little.

Alcohol abuse among young drinkers is less persistent over time than this same diagnosis in an older adult. About one-third of those diagnosed with alcohol abuse will still meet these diagnostic criteria five years later (Saunders, 2006). Two points are implied here. First, there really is evidence of maturing out of alcohol abuse for many individuals. Second, a subset of individuals with alcohol abuse will have a long career of alcohol problems, a portion of which will pose continued threats to public safety via drinking and driving.

The risk for future DUI recidivism involves risk factors that transcend and may be shared across the diagnostic boundaries of alcohol abuse and alcohol dependence. Instruments like the Hard Core Drinking Driver Checklist reflect these common risk factors shared by those who have one or the other diagnosis (White & Gasperin, in press).

Because of its heightened degree of severity and chronicity, those diagnosed with alcohol dependence should receive treatment of greater intensity and duration

than those diagnosed with alcohol abuse (Hoffmann & Hoffmann, 2003). The exception to this rule consists of persons diagnosed with alcohol abuse who present patterns of high severity and problem persistence. These individuals may require sustained treatment and monitoring on par with those diagnosed with alcohol dependence.

DUI offenders with multiple problems constitute a group at higher risk for problem chronicity and future DUI recidivism. A portion of DUI offenders also meet diagnostic criteria for drug abuse and dependence (other than alcohol) (about 4-10% and 20-30% respectively) (C'de Baca et al., 2004). In a recently published study, 77% of DUI offenders met criteria for alcohol abuse or alcohol dependence, 42% also met lifetime criteria for drug abuse or dependence, and 33% met criteria for a co-occurring mood or anxiety disorder (Palmer, Ball, Rounsaville, & O'Malley, 2007). Early treatment gains are less likely to be sustained for those DUI offenders with co-occurring drug abuse/dependence and psychiatric problems (Palmer et al., 2007).

The ability to resolve alcohol problems by altering the frequency, intensity, and contexts of drinking is dependent on problem severity (Larimer et al., 1998). The abstinence goal for those with alcohol problems grew out of experience treating persons in late stages of alcohol dependence whose moderation attempts had been consistently unsuccessful. Moderated solutions to alcohol problems for those with histories of alcohol dependence are unlikely, and even when achieved, difficult to sustain, as indicated by the fact that many who achieve temporary moderation eventually migrate toward abstinence. In contrast, moderated solutions to alcohol abuse seem to be the most common approach to resolving such problems among community populations, particularly young drinkers (White & Kurtz, 2006). The question of whether a person can make and keep decisions to reduce the frequency and quantity of alcohol intake and drink in ways that do not pose threats to the safety of themselves and others seems to rely, not on diagnosis, but on problem severity. As severity increases in each of these diagnostic categories, the odds of successful moderation of drinking decline[1] (for a more detailed discussion, see White & Gasperin, 2006). Individuals seeking reinstatement of driving privileges through the Secretary of State bear the burden of proof that their resolution goal (abstinence or moderation) is congruent with the intensity and duration of their drinking history/problems and that this resolution (abstinence or moderation) marks a sustainable pattern of stability rather than a brief, externally posed hiatus in their career of alcohol problems. Factors, particularly in combination, that may reduce the chances of successful moderation and increase the risks of sustained alcohol problems include the following:

- Family history of alcohol and other drug problems,
- Early age of onset of alcohol use,
- Developmental victimization (physical/sexual abuse),
- Presence of a co-occurring psychiatric disorder, and
- An alcohol-saturated social network.

Effectively treating those with the most severe alcohol problems, particularly severe patterns of alcohol dependence, benefits from new pharmacological treatments and new approaches to post-treatment monitoring. New medications such as naltrexone, nalmefene, and acamprosate have been shown to reduce post-withdrawal cravings for alcohol and reduce the rewarding effects of alcohol if it is consumed (Alcohol Alert, 2000; Volpicelli, 2001). Antidepressants, mood stabilizers, and neuroleptic (anti-psychotic) medications are

[1] "Moderation is defined as no more than one drink per day for women and no more than two drinks per day for men. A drink is considered to be 12 oz. regular beer, 5 oz wine or 1.5 oz 80-proof distilled spirits." Dufour, 1999, p. 13)

being increasingly used in addiction treatment to manage co-occurring psychiatric disorders. New monitoring protocol includes sustained "recovery checkups" that provide regular monitoring, support and, when needed, early re-intervention (Dennis, Scott, & Funk, 2003).

Effectively treating those with less severe alcohol and co-occurring problems will also require new treatment technologies. These technologies may involve different goals, different treatment philosophies and techniques, and different support groups. These technologies include brief interventions that have proven effective with those with less severe alcohol problems (Alcohol Alert, 2003).

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Citation: White, W. (2008) Alcohol, tobacco and drug use by addiction professionals: Historical reflections and suggested guidelines. *Alcoholism Treatment Quarterly*. 26(4), 500-535. Posted at **www.williamwhitepapers.com**

Alcohol, Tobacco and Other Drug Use by Addictions Professionals: Historical Reflections and Suggested Guidelines

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Abstract

Alcohol, tobacco, and other drug (ATOD) use by individuals working in the addictions field has existed as a complex, controversial personal and professional practice issue for more than 150 years. The central debate within this history involves the concept of nexus—the boundary that distinguishes rights to personal privacy from professional duties and obligations. Ambiguities related to this point of demarcation have contributed to misjudgments related to ATOD use by addictions professionals that have injured multiple parties. This essay reviews the history of ATOD use as a professional practice issue in the addictions field; discusses clinical, ethical, and legal issues related to ATOD use by addiction service professionals; and offers guidance on ATOD use decision-making.

Key Words: addiction counselors, ethics, impaired professionals, countertransference, professional practice

Acknowledgments: Support for this article was provided by the Great Lakes Addiction Technology Transfer Center (GLATTC) which is funded by the Center for Substance Abuse Treatment (CSAT). All opinions expressed here are those of the author and should not be interpreted as reflected the policies of GLATTC or CSAT. Joe Gay, Renée Popovits, Thomas Ramseyer, Jason Schwartz, Jerry Seaman, and Dave Sharar provided helpful comments and suggestions on the issues discussed in this paper.

Introduction

I entered the addictions field in the 1960s as a "streetworker" and aspiring "drug abuse counselor" at a time when few guidelines existed concerning the alcohol, tobacco, and other drug (ATOD) use decisions of service practitioners. Nearly forty years later, ATOD-related decisions remain an ambiguous and conflict-ridden area of personal/professional decision-making for preventionists, counselors, and others who work in the addictions field. Personal misjudgments within this arena have injured and ended careers, injured the reputations of addiction treatment institutions, and created a perceptual barrier that prevented individuals and families from seeking needed services.

In spite of its potential importance and its connection to the central mission of the field, ATOD use has existed only in the shadows of professional practice discussions. The subject is rarely broached inside service organizations and invisible in the field's professional journals and conferences. Knowledge of individuals disciplined or discharged for ATOD-related behavior and the circumstances surrounding such actions exist primarily in the arena of whispered gossip. And one of the most important of these issues—smoking as a professional practice issue for addictions professionals—is approached primarily through heated debates about organizational smoking policies. The time for more open and far-reaching discussions of ATOD-related decision-making by addictions professionals is long overdue. This article:

1) reviews the history of ATOD use and related problems as a professional practice issue in the addictions field;
2) defines ethical, legal, and clinical issues that arise in response to the ATOD-use decisions of addictions professionals; and
3) suggests guidelines for addictions professionals related to ATOD-use decision-making.

The focus of these discussions will be on the ATOD-related decision-making of the individual who works in the field, rather than the broader polices that addiction treatment organizations should adopt related to such use. The guidelines set forth here are humbly and respectfully submitted with full awareness that others of good faith and deep commitment to the addictions field will view some of these issues differently.

A Historical/Personal Retrospective

Early History

The earliest recovery mutual aid societies span eighteenth and nineteenth century Native American "recovery circles," the Washingtonian revival of the 1840s, recovery-focused fraternal temperance societies, the ribbon reform clubs, local recovery societies (e.g., the Drunkard's Club, the United Order of Ex-Boozers), and institutional aftercare groups (Keeley Leagues, Godwin Association) (White, 1998). Members of these organizations reinforced their own commitment to sobriety by performing rescue work with other alcoholics and by serving as temperance speakers and organizers. In these societies, personal recovery was viewed as an essential credential for reaching out to others who were addicted.

> *For the reformed inebriate knows each avenue to his brother's heart; he highly touches the string on which hangs all his sorrow; no rebuke mingles with his invitation of welcome...* (Woodman, 1843, p. 95).

Two problems arose within this early history. The competition between reformed men making public temperance speeches led to exaggerations and outright fabrications. Exposure of such mistruths, in a process remarkably similar to the recent controversies surrounding James Frey's *A Million Little Pieces*, discredited the larger recovery movement of that period (White, 1998). A

second problem was the relapse of reformed men who had become well known temperance lecturers/missionaries (White, 2000a). Men like Edward Uniac and Luther Benson, who tried to find sobriety on the temperance lecture circuit, suffered highly publicized relapses. Uniac died of an overdose of whiskey, bromides, and opium while on a temperance lecture tour in Massachusetts, and Benson drank his way into the Indiana Asylum for the Insane (Benson, 1896; Berry, 1871). Like many of his peers, Benson had thought that throwing himself into temperance work would quell his own appetite for alcohol.

> *I learned too late that this was the very worst thing I could have done. I was all the time expending the very strength I so much needed for the restoration of my shattered system* (Benson, 1896, p. 128-129).

Even John Gough, the most successful of all the nineteenth-century recovery missionaries, experienced several early relapses after beginning work as a temperance speaker (Gough, 1870). The public downfall of some of these early leaders reinforced the ways in which seemingly private behavior could discredit sobriety-based social movements.

The American Temperance Movement exerted an enormous influence on the rise of addiction treatment in the United States. The therapeutic branch of that movement performed rescue work with "drunkards" and advocated the creation of special institutions for the moral and medical care of the inebriate. All of its members had signed a personal pledge of abstinence before embarking on their rescue work. That influence also shaped the expectation that those working in early inebriate homes and asylums, addiction cure institutes, rescue missions, and inebriate colonies would model the sobriety they were helping others achieve (White, 1998).

In such an abstinent environment, even a past history of addiction could call into question one's ability to work in treatment institutions. A debate raged between the branches of the field on this question, with inebriate homes and some addiction cure institute leaders advocating that personal reform constituted a valuable credential in providing moral uplift for the drunkard, while leaders of the more medically oriented inebriate homes and asylums suggested that past addiction disqualified one for such work. Dr. T.D. Crothers argued this latter position with great passion in editorials that appeared in the *Journal of Inebriety* in the closing years of the nineteenth century.

> *It is confidently stated that a personal experience as an inebriate gives a special knowledge and fitness for the study and treatment of this malady. While a large number of inebriates who have been restored engage in the work of curing others suffering from the same trouble, no one ever succeeds for any length of time or attains eminence…Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic defects of the higher mentality…The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the work for any length of time* (Crothers, 1897, p. 79).

While there is evidence that some early addiction treatment practitioners suffered relapses resulting in death or disengagement from the profession (White, 2000c), these events appear to be the exception to otherwise significant contributions by recovering people working as physicians and managers within early inebriate treatment institutions.

The Middle Years

The debate over the question of alcohol and drug use by the addictions professional died in the early twentieth century in the larger collapse of addiction treatment as a professional field. As the larger field faded into obscurity, local experiments in addiction treatment continued, the

most significant of which were the lay therapy movement started in Boston and the brief spread of morphine maintenance clinics. The roots of the lay therapy movement can be traced to Boston, where the leaders of the Emmanuel Episcopal Church established a clinic to treat nervous and mental disorders via the integration of religion, psychology, and medicine.

Rapidly developing a specialty in the treatment of alcoholism, the Emmanuel Clinic developed techniques to treat alcoholics and to then recruit and train some of those treated as lay alcoholism psychotherapists. Individuals such as Courtenay Baylor, Francis Chambers, Samuel Crocker, James Bellamy, William Wister, and Richard Peabody were treated within this lay therapy tradition and went on to long, often distinguished careers as lay therapists (White, 2000b).

The continued abstinence of the lay therapists was a cornerstone of their work, as disclosure of their own recovery stories and recovery maintenance strategies was central to their approach to alcoholism therapy. The precise support mechanisms used by these lay therapists to sustain their recoveries is unclear. There was a support structure available (the Jacoby Club), but there is no evidence that the lay therapists participated in the Club. Problems of relapse among some of the lay therapists (Wister, Crocker, McKay, and Peabody) raised questions about the potential to replicate lay therapy broadly across the country (McCarthy, 1984), but this role was sustained through the 1940s, 1950s, and 1960s (by such noted lay therapists as James Lamb Free) and constitutes an important precursor to modern addiction counseling (Anderson, 1944; White, 1998).

Very little is known about those working in the morphine maintenance clinics that briefly flourished between 1919 and 1924, although there is evidence that Dr. Charles Terry, one of the pioneers of the morphine maintenance clinics, developed severe alcohol-related problems later in his career (Courtwright, 1986). Terry's experience illustrates one of the anomalies of the addictions field: the vulnerability of those who work in the field to develop ATOD-related disorders. Whether this is a result of the attraction of those with increased vulnerabilities to the field, or of some contagious element activated by sustained exposure to the field, remains a question of some speculation. What is clear is that the ATOD-related impairment of service professionals within the field has long served as a stain on the field's professional and cultural credibility (White, 1998).

Multiple service roles followed the founding of Alcoholics Anonymous (AA) in 1935. Sponsorship evolved within AA in the early 1940s, and AA members who were physicians and nurses worked within newly opening "AA Wards," "AA Farms," and "AA Retreats" (Anonymous, 1952). Such roles became more formalized in the emergence of the Minnesota Model in the late 1940s, with the State of Minnesota establishing a "counselor on alcoholism" civil service title in 1954. The spread of this model and the continued lay therapist role within new experiments with outpatient alcoholism clinics set the stage for the emergence of the modern alcoholism counselor role (White, 2000b).

This emergence was marked by considerable debate over the question, "Who is qualified to treat the alcoholic?" What became known as the "Krystal-Moore debate" characterized the poles of this controversy. Dr. Henry Krystal argued that only the psychoanalytically trained psychiatrist was equipped to treat the alcoholic and that the lack of such training rendered one ineffective and potentially dangerous. Dr. Robert Moore took the opposing position that individual psychotherapy was not the treatment of choice for alcoholics, and that lay counselors, if supervised by professional psychotherapists, could provide effective support for recovery initiation (Krystal & Moore, 1963). One of the wise leaders of the modern treatment field characterized this prolonged debate as "noisy emotional outbursts launched from shaky premises on both sides" (Ottenberg, 1977, p. 56). Significant for our current discussion is the fact that neither Krystal nor Moore identified past addiction or present abstinence as a critical qualification for those treating people addicted to alcohol (McGoldrick, 1964).

The rationale for the training of those in recovery to serve as alcoholism counselors was that they could offer living proof of the transformative power of recovery, serve as a role models of

sobriety-based problem-solving, establish empathy and communication with alcoholics who bristled at professional authority, and help orient clients to the program of Alcoholics Anonymous (Blume, 1977). It was through these roles that personal abstinence and recovery served as a credential in the gestation and birth of alcoholism counseling as a profession. At the same time, it created early ambiguity and conflict related to the delineation of the roles of A.A. sponsor and lay therapist (counselor).

Modern History

My own personal/professional history reveals the evolving ambiguities and contradictions related to ATOD use by addictions professionals in the modern era. I entered the addictions field at a time it was really two fields: an alcoholism field and a drug abuse field. I worked with a foot in each of these fields as a self-identified "ex-addict" whose beliefs were shaped most heavily under the tutelage of Gateway House, an early therapeutic community (TC). At Gateway, like most of the TCs of this period, drinking was accepted and even promoted to clients via earned drinking privileges, and occasional social drinking was the norm among TC staff. Alcohol was simply not seen as a "drug." The growing prevalence of alcohol problems among "ex-addict" staff slowly altered that perceptual blindness (White, 2007).

A symbolic event marked the field's need to end its segregation between alcohol and drug camps. In 1978, Charles Dederich, the founder of Synanon— the first ex-addict-directed therapeutic community (Janzen, 2001)—was arrested. The scene of Dederich being carried in a state of extreme drunkenness into police custody (for charges of conspiracy to commit murder) constituted vivid testimony of the flawed dichotomization between alcoholism and addiction treatment and recovery. Dederich's plummet from power offered convincing testimony that professional pioneers, through their own personal decisions and behaviors, could wound the very fields they had earlier nurtured into existence.

Persons recovering from alcoholism were the mainstream workforce of the alcoholism programs of the 1960s and 1970s that were spawned by funds from the Office of Economic Opportunity (OEO), the National Institute on Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). These programs grew explosively in the early 1970s at a time when few guidelines existed on how to recruit, select, orient, train, and supervise recovering people, who were then branded as "paraprofessionals." Fueled by a growing body of knowledge suggesting the potential effectiveness of peer-facilitated models of change (Riessman, 1965; Durlak, 1979; Hattie, Sharpley & Rogers, 1984), particularly within the arena of addiction recovery (Brown & Thompson, 1976; Longwell, Miller, & Nichols, 1978; Connett, 1980)[1], recovering people with little sobriety time were thrust into positions characterized by low pay, poor role definition, and excessive demands for time and emotional energy.

Concerns about the relapse of counselors grew as this "new profession" came of age (White, 1979; Kinney, 1983; Wilson, 1984). That many recovering people went on to become leaders within this field under such circumstances is testimony to the transformative power of recovery that masked the casualties of many of their peers. The growing consciousness of such casualties led to the expectation that those first certified to work in the field would have "no history of alcohol or drug misuse for a minimum of two years immediately prior to certification" (From the 1974 Littlejohn Report, Quoted in Blume, 1977, p. 563). Recovering people working as alcoholism counselors were expected to have two-to-five years of stable sobriety and sustain their sobriety through "working the program"—active involvement in A.A. or Al-Anon (McInerney, 1973).[2]

With the rapid diffusion of methadone maintenance treatment (MMT) in the late 1960s and early 1970s, methadone-maintained counselors were caught in a purgatory of conflicting

[1] Such studies have continued. See Aiken, LoSciuto, Ausetts, & Brown, 1984; Blum and Roman, 1985; Galanter, Castaneda & Salamon, 1987; McGovern & Armstrong, 1987; Stoffelmayr, Mavis & Kasim, 1998)

[2] Sobriety requirements changed during this early history, with the early OEO alcoholism programs of the 1960s requiring only one year of sobriety for their counselors.

messages. Clinic doctors defined methadone as a life-saving medicine, while professional critics, social activists, friends, family members, and former-addict peers often characterized methadone as a "technological fix," a substitute high ("poor man's heroin"), a genocidal poison, or a confession of street incompetence (e.g., "methadone is for losers"). The low-dose policies and scarcity of recovery support services in MMT clinics of this era generated high relapse rates and high rates of secondary drug use. Alcohol problems and relapse to opiate addiction were common occurrences—among clients and staff. The highly stigmatized status of methadone left the lives of many methadone clients and methadone-maintained staff hiding their "dirty little secret"—a status that remained in the decades that followed, in spite of overwhelming scientific evidence of the effectiveness of MMT (Murphy & Irwin, 1992).

The polydrug counterculture of the 1960s generated its own brand of folk healers and service workers via the emergence of crisis and drop-in centers (including "acid rescue"), free clinics, rock festival medicine, drug-testing services, outreach ("streetwork") programs, outpatient counseling clinics, and "crash pads." Drug use by those working in these institutions was seen more as a badge of cultural membership than a breach of ethics, although there was an emerging etiquette about not "holding" while you were at the service facility and not being "stoned" or "tripping" during your shift. The line between service provider and service recipient was a fluid one in this world, with many individuals cycling in and out of both roles. A core of these early workers matured out of such use; migrated into structured programs of recovery; or attempted, not always successfully, to continue drug use (e.g., smoking marijuana) in secret.

As money flowed into the field in the 1970s and 1980s and the field became a less stigmatized professional arena, growing numbers of psychiatrists, psychologists, social workers, and business entrepreneurs arrived. Some were drawn to the field's frontier status. Others were drawn to the field to work out their own problematic relationships with alcohol and drugs or to sort out having survived families with such problems. Consciousness of, and contradictions related to, such problems were magnified when addiction services were integrated into the traditionally heavy drinking cultures of mental health and criminal justice institutions in the 1960s and 1970s.

The diverse populations that made up the addictions workforce in the 1970s did share one thing in common: daily rituals of massive nicotine and caffeine consumption. The full spectrum of ATOD use was most evident at the field's early state and national conferences. In the evenings at such conferences, workers in recovery clustered within Twelve Step meetings filled with tobacco smoke and caffeine-fueled exchanges of experience, strength, and hope. Outside those meetings, heavy drinking was the norm, and the pungent smell of marijuana in the hallways of conference hotels was common.

That abstinence-based treatment philosophies emerged from such polypharmacy is itself an irony of history, created in good part by the influence these early groups exerted on one another. The growing integration of alcoholism and drug abuse programs within what was then called "combined treatment," and the eventual larger integration of the two fields into one[3], brought new ethics and etiquette surrounding alcohol and other drug use. There were several factors that contributed to this process, including the alcohol problems of ex-addict staff; the "pill" problems of some counselors in alcoholism recovery; the recognition of multiple drug use by a growing number of clients; the growing linkages between treatment programs, Alcoholics Anonymous, and Narcotics Anonymous; and the rapid professionalization of the role of addiction counselor.

As "recovery" took on a broader definition, many workers in the field shed "secondary drugs" or carefully limited their exposure to such substances. After seeing some of my ex-addict peers develop severe alcoholism, reviewing my multigenerational family history of alcohol/drug problems, and assessing my own relationship with alcohol, I joined many in the field who stopped drinking by choice or necessity long after we had defined ourselves as people "in recovery." By the mid-1980s, the field had sobered itself under the influence of the "recovery movement" and

[3] The most intense period of this conceptual and organizational integration spanned the years 1975-1985.

a larger sobering of America that some christened the “new temperance movement.” The exception to this chemical shedding was the continuation of widespread nicotine and caffeine dependence among addictions professionals. Such dependence remained invisible as a professional and ethical issue, but this was about to change as well.

The addictions field reached a “tipping point” in the late 1980s and 1990s on the issue of nicotine, and excessive caffeine use moved into visibility as a personal and professional issue (Knapp, Rosheim, et al., 1993). It was during this decade that the addictions field and the larger culture began the painful process of redefining its perception of and relationship with tobacco. I stopped smoking in 1988 and shortly afterward terminated the last of my excessive chemical relationships (caffeine). The decision to quit smoking was prompted by individuals who confronted me about the incongruity between my role as a visible trainer in the addictions field and the behavior that I was modeling both to my professional peers and to consumers of addiction treatment services. I reached a point of consciousness that I simply could not continue in this field while in a state of active addiction. In the years that followed, controversies raged (and continue) over program smoking policies for clients and staff. The result was that a growing number of workers in the field, many of whom had for years touted their sobriety and clean time while chain-smoking cigarettes, began severing their relationships with this most lethal of drugs. Collectively, it was like blinders had been peeled off our eyes as we asked ourselves how we had for so long refused to define nicotine as an addictive drug. It will take another decade for the attitudinal shift about nicotine to reach full fruition, but the die has been cast and is now irretrievable.

As the field began the process of painfully shedding its addiction to nicotine, it became a wetter field through an evolution in its workforce composition. The progressive escalation of educational credentials flowing from counselor certification and licensing standards reached a crescendo in the 1990s, pushing many recovering people out of the field and bringing many allied professionals into the field. This brought a higher proportion of people into the field who were alcohol users and a new generation of young people who were emerging from the binge drinking and new polydrug experimentation of the 1990s.

An interesting change in status occurred during the 1980s and 1990s for those working in the field with recovery backgrounds. Personal or family recovery experiences became a less desirable credential in the rush toward professionalization. The percentage of people working in the field in recovery declined, and those who brought such backgrounds referenced this status less frequently. There was in this move toward professionalization an implicit assumption that those working in the lay therapy tradition without formal, advanced academic credentials were somehow less effective in their clinical work with clients, but there was little evidence to support this assumption.

Studies comparing recovering and non-recovering addiction counselors concluded that recovering counselors are more likely to be older, to be male, to be less educated, to value recovery experience more than education, to feel more positively about their jobs, are to use a broader menu of treatment goals and techniques (McGovern and Armstrong, 1987; Blum & Roman, 1985; Stoffelmayr, Mavis & Kasim, 1998; Stoffelmayr, Mavis, Sherry & Chiu, 1999), but that they do not differ on critical performance measures. For example, no differences between recovering and non-recovering counselors were found related to such measures as client affiliation rates or post-treatment recovery/relapse rates (Machell, 1991; Brown & Thompson, 1976; Longwell, Miller & Nichols, 1978; Connett, 1980). A single study evaluating client perceptions of counselor backgrounds found that clients viewed those with more professional training as more trustworthy and expert regardless of recovery background (LoBello, 1984), and another found that clients of professionally educated counselors were more likely to be enrolled in educational programs following treatment than clients of recovering counselors who lacked professional education (Aiken, LoSciuto, Ausetts & Brown, 1984). One could read in the current proliferation of non-clinical recovery support roles (e.g., outreach workers, recovery coaches, personal recovery assistants, recovery support specialists) a

backlash against the over-professionalization of the role of addiction counselor (White, 2004a). This latest shift is bringing a new generation of recovering people into service roles in addiction treatment and grassroots recovery advocacy agencies.

It is obvious from this brief summary that my motivations for writing this article are numerous: grief over the ATOD-related loss of professional peers, unabashed survival guilt, a desire to help a new generation of addictions professionals, and hope that I might contribute something of value to the ethics and etiquette of this most unusual and rewarding profession. Perhaps more than anything, I am weary of helping clients and colleagues celebrate their recoveries from addiction to alcohol, opiates, and stimulants, only to watch them later die premature deaths due to the consequences of nicotine addiction. I am also concerned about the addictions field's tenuous, probationary status within this culture and believe that anything that hurts the image of the treatment field—including ATOD-related incidents of its practitioners—contributes to the potential revocation of our legitimacy as a cultural institution.

As a field, we have entered the twenty-first century with the most diverse workforce in our history—a diversity that is again raising questions about what appropriate stance addictions professionals should take regarding their own ATOD-use decisions. For the foreseeable future, that decision-making will continue to take place within an evolving history filled with many contradictions and ironies. If one looked at this field from the outside in, a number of such contradictions would be puzzling.

- We are a field that historically has defined abstinence from certain drugs (e.g., alcohol, heroin) and dependence on other drugs (e.g., nicotine, caffeine) as criteria for in-group occupational status.
- Service professionals with AOD problems who are not self-identified as being "in recovery" face no length-of-sobriety requirements and may be hired and work without notice in the field until those problems affect their performance.
- Persons who self-identify as being in recovery face length-of-sobriety requirements not applied to other staff.
- Professionally credentialed counselors in recovery who withhold that recovery status may work in the field with less than minimum sobriety requirements, but could not do so if they were honest about their lengths of sobriety.
- People who experience and are treated for other health problems (including other behavioral health problems) may continue working in the addictions field as long as their problems do not affect their performance. Following treatment of other problems, they are allowed to return to work as soon as their physicians release them, but they may not do so following treatment of AOD problems.
- Addiction treatment programs promote employee assistance programs that recommend treatment as an alternative to terminating AOD-impaired employees, yet often do just the opposite with their own employees.
- There are programs that prohibit counselors from disclosing whether they are in recovery or not, yet demand to know the recovery status of each job applicant for a counseling position.
- There are programs that require evidence of pre- and post-hire participation in a particular pathway of recovery (e.g., Twelve Step meetings for those in recovery), but do not expect such participation for non-recovering staff.

As this discussion proceeds, we will try to explore the basis for such contradictions and the best ways of charting our path through this ill-marked and sometimes hazardous territory.

Defining Nexus: Rights to Privacy vs. Professional Duties and Obligations

Most addictions professionals would agree that there are spheres of their lives that are outside the arena of appropriate scrutiny by their employers and their professional organizations. Most would also agree that work in the addictions field brings duties and obligations that transcend the workplace and one's working hours. The troublesome question, therefore, is, "Where does one draw the line between rights to privacy and professional duties and obligations?" There is a substantial body of legal and ethical literature suggesting that an individual's private behavior is precisely that until there is a nexus—an inextricable connection—between private behavior and one's professional performance (White and Popovits, 2001).

Ethically speaking, the ATOD use of addictions professionals during non-work hours is not subject to professional scrutiny until that behavior harms their ability to perform professionally or otherwise inflicts harm to other persons or institutions. LeClair Bissell and James Royce, authors of the first ethics text for addiction counselors, argued that there was a clear nexus on the issue of personal alcohol/drug use.

> *If there are complaints that private life is just that and not the concern of the employer or colleague, it is quite fair to reply that, in this particular field, the use of chemicals and one's belief system about them is job related* (Bissell & Royce, 1987, p. 10).

Before exploring specific case studies of ATOD-related professional practice issues, we will try to shed more light on this concept of nexus. Personal ATOD decisions are best filtered through some of the core values that have historically guided helping professionals (White & Popovits, 2001).

- The value of **obedience** dictates that addictions professionals adhere to the promises made to comply with laws and regulations governing their employment and their profession, e.g., compliance with ATOD use-related standards in personnel policies and professional codes of ethics linked to certification or licensure.
- The value of **competence** demands that addictions professionals not do anything that would compromise their professional decisions and behaviors, e.g., performing professionally while under the influence of alcohol.
- The value of **honesty** makes it incumbent upon addictions professionals to accurately represent statements they choose to make related to their ATOD use history and their recovery history and status.
- The values of **fidelity** and **loyalty** demand that addictions professionals maintain their fiduciary obligation to serve the needs of their clients and protect the integrity of their service organizations and the addictions field.
- The value of **non-malfeasance** is a call to refrain from hurting anyone through the performance of one's professional role, e.g., injury of a client due to one's personal impairment.
- The value of **self-interest** recognizes the need for service professionals to protect themselves, both in terms of their physical/psychological safety and in terms of their professional reputation.

All of these core ethical values have potential relevance to situations involving ATOD-related decisions on the part of addictions professionals.

Another way to approach ATOD-related decisions is to ask oneself who stands to benefit and who could be injured by a particular ATOD-related decision. ATOD decisions constitute an arena of *multi-party vulnerability*. That means that multiple parties—the addictions professional,

past/present/potential service consumers, the service organization, the larger professional field, and the community—could be injured by the addictions professional's ATOD-related decisions.

ATOD-related Professional Incidents

With this background laid, we will further explore how this nexus occurs between our private and professional lives. We will do this through brief vignettes drawn from the author's consultations on ethical issues that have arisen within treatment organizations around the country.[4]

1. *Substance-related Impairment of Performance during Scheduled Work Hours*: Raymond had worked as a counselor for two years within the addictions field prior to the day he arrived at work under the influence of alcohol. The resulting suspension and intervention led to his admission to alcoholism treatment and his subsequent decision to work outside the addictions field during his early recovery. Raymond's behavior illustrates one of the most direct ways in which one's personal relationship with alcohol or drugs, in this case a troubled relationship, can ripple into the arena of professional performance. Other cases involve less obvious effects on performance, e.g., missed work, feigned sickness due to hangovers or withdrawal, anxiety and depression, deterioration of clinical effectiveness.
2. *Substance-related Impaired Performance While "On Call"*: Marybeth responded to an emergency call from a local hospital and felt that she had handled the situation just fine until the client's spouse filed a complaint that Marybeth was "reeking of booze" when she arrived at the hospital emergency room to conduct the interview. Marybeth's response was that she had consumed a beer with her dinner but suffered no impairment of any kind. The distinction between "use" and "impairment" are sometimes indefinable in such situations. Marybeth's behavior injured her own reputation and that of her agency. She was disciplined for violation of the agency policy related to consumption of alcohol while carrying a pager.
3. *Substance-related Deterioration in Self-care Responsibilities that Affect Professional Performance*: Fred tried to compensate for his increased drinking away from work by spending more hours at work as an intake worker at a treatment agency. The combination of increased alcohol intake, excessive work, and decreased sleep took its toll on his health and his performance. Ironically, the earliest sign of later troubles in this case was an increase in perceived productivity. A year later, everyone knew something was going on with Fred, but no one was sure what.
4. *Allegations of Substance Impairment*: After a sustained cold, Cathy received a prescription from her physician. Over the next two days at her job as an addictions counselor, Cathy became quite disoriented, giddy, and light-headed, and was forced to go home early on the second day. Several of the clients in treatment were whispering that Cathy was stoned. In another example, when Barry's clinical supervisor confronted him about what appeared to be substance intoxication, he acknowledged that he was taking a prescription for anxiety. Further investigation revealed that Barry had taken three times the prescribed dose.
5. *Substance-influenced Breaches in Relationships with Clients*: Lionel, an addictions counselor, resigned amidst allegations of financial and sexual exploitation of clients. A close review of his caseload revealed other simultaneous cases of clinical abandonment (service disengagement, fabrication of clinical contacts). Upon further investigation, it appeared that these behaviors followed on the heels of Lionel's relapse to cocaine addiction.
6. *Positive Random Drug Test*: Many addiction treatment agencies or units are governed by drug-free workplace policies that call for random drug testing. Robert had been viewed as an exemplary employee until he tested positive for cocaine on a random drug test. When another employee, Shandra, was called to take a random drug test, she reported that she had taken a prescription narcotic, tested positive for the drug she reported consuming, but could not

[4] All names in these incidents have been altered.

produce a prescription for the drug, as her husband had given her one of his pills after she had strained her back—a technical case of illegal drug use.

7. *Contraband***:** An even more direct violation of drug-free workplace policies involves bringing alcohol or other drugs and related contraband into the addiction treatment workplace. Thea's alcohol problem remained hidden until a secretary sent to retrieve a file found a bottle of bourbon in the back of a drawer in Thea's desk—a significant breach of agency policies prohibiting bringing contraband into the workplace.
8. *Substance Use/Misuse in the Community while Acting in One's Professional Role***:** Brady was assigned to do a speaking engagement at a local service club, in which he provided an overview of his agency's addiction treatment services. The following day, the director received a call in which he learned that Brady had liberally availed himself of the open bar before he was due to speak, and that his words were slurred during his speech. This complaint reflects ways in which ATOD-related behavior in the limbo between personal and professional time can be problematic for workers and treatment organizations. The most frequent issues that arise in this area are related to behavior at professional meetings or conferences.
9. *Substance Use/Misuse in the Community on One's Own Tim***e:** Mary is a 22-year-old recent college graduate who works in an adolescent addiction treatment program. As her supervisor, you have received several complaints that Mary has been seen drinking heavily at some of the most notorious "party bars" in your community. It has also come to your attention that Orville, a preventionist who has major responsibility for providing anti-tobacco education in the local schools, is smoking in public. Are these private behaviors or professional practice issues? These examples illustrate how the off-work behavior of individuals working in the addiction field can raise professional practice issues that affect the reputations of service workers, service organizations, and the larger field. Many addiction treatment organizations have codes of professional practice that explicitly define expectations in this area.
10. *Arrest/Conviction on a Substance-related Violation***:** Andrew, an addictions counselor, was arrested in an undercover sting for solicitation of prostitution, and was charged with possession of marijuana at the time of his highly publicized arrest.
11. *Loss of Work Credentials***:** Marty, a member of the maintenance staff at an addiction treatment organization whose duties involved driving, lost his driver's license due to a driving while under the influence conviction following his arrest during non-work hours. Beatrice, a nurse working in a detox unit, lost her nursing license following her conviction for forging prescriptions for narcotic drugs.
12. *Relapse of Person for Whom Recovery Status is Linked to Job Performance***:** Felicia works as a recovery coach in a local addictions treatment program. The supervisor received a report from another staff person that Felicia was observed drinking over the weekend at a concert in a neighboring community. Felicia represents herself as having been in continuous recovery for the past three years. There are several issues here, including the potential effects of Felicia's apparent relapse on her own health and career and the effects that Felicia's behavior/status could have on her clients and on the organization. Multiple professional practice issues are evident in this vignette, including the issue of misrepresentation of credentials within a role in which stable recovery is a core credential.

    In another example, Jeremy self-identified as a person in recovery when he was hired as an addictions counselor and has represented himself as being in recovery for eight years. When questioned about being seen consuming alcohol, Jeremy responds that alcohol was not the drug to which he was addicted, that he has no problem with alcohol, and that his recovery status is based on his last date of heroin use. The situation with Jeremy raises questions about secondary drug use for people in recovery and forces a deeper exploration of the very definition of recovery. There are no universally accepted standards regarding

what drugs are embraced within the definition of recovery, what constitutes a relapse, and when one is ethically bound to report ATOD use or related problems to one's supervisor.

13. *Dual Relationships*: A final example of nexus arises when relationships linked to one's past AOD use resurface in the treatment setting. Theresa, an addictions counselor, admitted to her supervisor a year ago that she had developed an addiction to cocaine. After taking a leave of absence to go through treatment, she returned in a non-service role and has recently returned to a counseling role. Today she recognizes among clients being admitted to treatment a person from whom she purchased cocaine several times.

These vignettes illustrate the wide variety of ways in which one's ATOD-related decisions can ripple into the arena of professional practice. Before offering guidelines relevant to these situations, we will explore ways in which personal ATOD decisions of addictions professionals can influence service relationships and the service process.

ATOD Use, Transference, and Countertransference

Transference is a term used to describe ways in which a client's experiences (feelings, perceptions, expectations, behavioral patterns) in his or her most significant prior relationships are projected into his or her relationship with the addictions professional. *Countertransference* is the term used to describe the total emotional reaction of the addictions professional to each client—responses that can involve projections from the therapist's own past relationships, the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983). Countertransference is composed of both collective sentiments (those based on categorical responses to such issues as race, gender, age, sexual orientation, type of AOD use) and idiosyncratic sentiments (those based on unique emotional reactions of the counselor to a particular client). In psychoanalytic thinking, the manner and degree to which these transferences and countertransferences are actively managed exert a profound influence on the outcome, good or bad, of the helping process. The addictions professional's own ATOD-related attitudes and behaviors elicit transference responses from clients, and each client's unique ATOD-related behaviors and lifestyle elicit feelings from the addictions professional that can help or hinder the helping process.[5] In this section, we will explore how one's own ATOD-related history and current ATOD use decisions can influence one's service relationships.

In 1963, Dr. Henry Krystal suggested an important proposition:

> *Since the therapist is his own working tool, he must be freed from blind spots and inhibitions. Only in this way can he make constructive use of his countertransferences, rather than have them disturb the treatment, or his own life, or both* (Krystal & Moore, 1963, p. 711).

Knowledge of addiction and recovery is a critical competency of addiction counselors. Such knowledge and its effective use have not been found to be contingent upon recovery status, and the effects of the counselor's past or present ATOD use have not been a subject of focused study in the field. Historically, we have focused on recovery status and length of sobriety for individuals seeking to work in the field because of the close nexus between this status and the mission of the field, but the broader spectrum of ATOD use status has not been a visible issue.

There are many things that combine with ATOD use patterns to affect counselors' credibility and their service relationships. Differences in credibility and effectiveness, for example, could be compared across several subgroups of clinicians, including:

[5] One's ATOD history and decisions can also influence the clinical supervision relationship (See Culbreth and Borders, 1998).

- Persons in recovery with educational preparation,
- Persons in recovery without educational preparation,
- Persons with no personal recovery experience, but with addiction and recovery experience within their families,
- Persons with no personal recovery experience, with addiction experience in their families, but with no recovery experiences in their families,
- Persons with no personal recovery experience with educational preparation,
- Persons with no personal recovery experience and no educational preparation, and
- Persons with no personal recovery experience, but who are developing or are now experiencing AOD-related problems.

The closest we have come as a field to identifying such subgroupings is a Michigan study (Stoffelmayr, Mavis, & Kasim, 1998) that surveyed 634 staff members of 51 treatment programs and found that 44% of respondents identified themselves as non-recovering, 30% as recovering, and 26% as not recovering but part of a family that had experienced addiction or recovery.

The effect of past or current ATOD use on clinical effectiveness remains a question ripe for theoretical speculation and scientific study. As a close observer of this issue for nearly four decades, I would offer the following observations about how our past or current ATOD use experiences can enter into our service relationships.

A counselor's history of living in environments without ATOD-related problems and the ability to control his or her own ATOD relationships may convey either incomprehensibility (at best) or an air of superiority and condescension (at worst) to clients who lack volitional control over such relationships. The potential of such attitudes to disrupt treatment led Howard and Hurdum to make the following declaration in 1940:

> *It is essential that complete abstinence be advised to the patient. Accordingly it is advisable that the therapist himself abstain, lest his acts or attitude seem to imply "you must not drink, but it is all right for me to do so as I am a superior person"* (Howard & Hurdum, 1940, p. 357).

Not everyone would agree with this admonition, but the observation of Howard and Hurdum underscores subtle ways in which the therapist who has no history of ATOD problems can inadvertently express contempt toward those who do. One factor that historically distinguishes addictions professionals from other service professionals who interact with those with severe AOD problems is a service relationship based on moral equality and emotional authenticity (White, 2004b). But as we shall see, recovery alone does not ensure such a relationship, nor does lack of recovery status prevent one from developing such a relationship.

Counselors with past and current moderate ATOD relationships may also tend to expect or try to cultivate in their clients the same type of rational control over ATOD consumption that has worked successfully in the counselor's life. There is little in the normal user's experience that will provide an understanding of the addicted client's loss of volitional control over the timing, location, quantity, and consequences of ATOD use.

> *Jerome was hospitalized via the emergency room for unbearable pain (self-described as "a knife being pulled across my abdomen") related to acute alcoholic pancreatitis. He was heavily medicated with narcotics for more than two weeks before his condition stabilized enough to consider discharge. Each day of his stay, his physician and nurses communicated to him that this intense pain would return every time he drank. Upon his discharge, Jerome went to his car, reached for the bottle under his seat, and began drinking. He was readmitted before he ever left the hospital grounds.*

For those who haven't experienced addiction close up, such behavior can be completely inexplicable and result in frustration and anger at the client's continued self-destruction, the therapist's emotional disengagement from the service relationship, and "therapeutic discharge" of the client for what appears to be willful recalcitrance.

Those workers with developing or unacknowledged ATOD problems may tend to underestimate the severity of ATOD problems in others as a way of minimizing their own emerging problems or try to work out these emerging problems via their clinical work with clients (McInerney, 1973). This underscores the need for service professionals who use psychoactive drugs of any kind to make regular effort to evaluate the effects of such use on their own lives and on their professional work with others. The goal in suggesting this is not a masked attempt to sober up the entire addictions treatment workforce. It is intended to prevent the spillover of personal ATOD issues into the addictions professional's service relationships. There is little doubt, for example, that the widespread addiction of the treatment workforce to nicotine has dramatically slowed the process of acknowledging and assertively treating nicotine dependence within addiction treatment programs and fueled myths that supported this delay (e.g., the myth that quitting smoking and quitting drinking at the same time increases the risk of relapse).

Counselors (those without and even those with addiction histories) may unconsciously act out social and professional stigma linked to addiction, making assumptions based on misguided stereotypes and conveying feelings of contempt toward persons with certain drug choices and addiction-related lifestyles. Such contempt can arise from the social values one has learned as a member of this culture or through one's past experiences with these issues, either personally or in one's own family and social network. Counselors in recovery may respond to the internalized stigma associated with their addiction/recovery status through competition and conflict with other professionals, overcompensation (excessive hours), over-identification with clients, estrangement from their own recovery support groups, and relapse (Blume, 1977).

As noted earlier, those without ATOD histories who become addictions professionals can bring attitudes and subtle behaviors that signal an air of moral superiority to clients. The same can occur among those with addiction backgrounds. It is important to remind oneself of the strange pecking order within cultures of addiction through which members of each group elevate themselves by castigating those in other groups. Historically, "alkies" and "junkies" held each other in mutual contempt, and even the classic junkie world had a status order ranging from the "gutter hype" to the "righteous dope fiend." The point to be made here is that the prior positions one held and the attitudes endemic to those positions can be inadvertently brought into one's later career as a counselor.

Counselors in personal recovery from severe drug dependence can be particularly prone early in their counseling careers to see all AOD problems through the addiction lens. In this case, their abstinence becomes a distorting lens that sees all use as addiction and any failure to admit an ATOD problem as the "disease of denial." Some recovering counselors may also be prone to program the recoveries of those with whom they are working through the counselor's own narrow band of recovery experience.

This is a good time in our discussion to reaffirm the obvious: recovery status or abstinence by itself is not an addiction counseling credential—an insight recognized very early in the modern history of addiction counseling.

> *The former problem drinker, however, who controls his drinking on the basis of his A.A. activities, but who has not discovered and effectively worked through his own emotional problems, is in a worse position to function as an individual therapist to the alcoholic than a person without a history of alcoholism in the past but with no experience* (Krystal & Moore, 1963, p. 710).

> *A person who after some years of sobriety still attends AA seven nights a week has not yet learned to play, relates poorly to the opposite sex and to family, and has little interest*

in anything other than alcoholism. Such a person is scarcely an ideal candidate [for the role of alcoholism counselor] (Bissell, 1982, p. 811).

I would add to Krystal and Bissell's observations that, even for the most fully actualized person in recovery, recovery status alone is not a sufficient foundation for addiction counseling.

All ATOD-related decisions and experiences constitute potential sources of bias. For example, where counselors in short-term recovery are prone to work out their own immediate recovery issues through their clinical work with clients, I have observed counselors in long-term recovery reaching a point of detachment from their addiction histories, losing their capacity for empathic identification, developing an air of moral superiority, and exhibiting great intolerance of and anger toward the actively addicted. This is analogous to highly successful minority group members who exhibit great contempt for those within their own ethnic group who exemplify racially stereotyped behavior.

There are several ways in which the addictions professional's ATOD use can influence clients, e.g., what the client observes or hears from others about the counselor's ATOD-related behavior, what the counselor tells the client about such behavior, or what the client senses or suspects about such behavior. One of the most obvious ways is through the behavior modeled by the service professional. Clients can share or take on a counselor's current addictive behavior and use the counselor's behavior to justify addictive thinking and behaviors (e.g., "if it's okay for my counselor to smoke, it's okay for me to smoke"). The most direct way in which the counselor's own ATOD history influences the client and others is through the act of self-disclosure of past or current ATOD experiences.

The Ethics and Etiquette of ATOD-related Self-disclosure

There are several rationales for counselor self-disclosure in the addiction treatment arena. Such disclosures can be aimed at lowering resistance, enhancing engagement, diminishing isolation and shame, enhancing hope, and illustrating particular problem-solving strategies. Self-disclosures are less in vogue today as a result of the professionalization of addiction counseling. Volunteering information or responding to questions about one's past or current ATOD experiences is a potentially troublesome area best sorted out within the larger context of the ethics of all self-disclosure in the clinical setting. The most significant issues related to counselor self-disclosure include problems of:

- lost focus, e.g., disclosures that divert the interview from the experience of the client to the experience of the counselor;
- inappropriate timing, e.g., disclosures that slow the development of or abort the therapeutic relationship;
- duration, e.g., disclosures of excessive length that constitute a form of introspective disengagement on the part of the counselor;
- immediacy, e.g., communicating current experiences from the counselor's personal life about which the counselor lacks objectivity and emotional control;
- inappropriate levels of intimacy, e.g., excessively intimate disclosures that diminish a client's feelings of physical and psychological safety in the service relationship or diminish the client's confidence in the abilities of the counselor; and
- cultural violation, e.g., disclosures that violate cultural etiquette.

There are also problems that can arise related to counselor disclosures of past or current ATOD use in professional settings (e.g., as a professional trainer), during presentation to the public, or in interviews with the media. The problems that arise related to trainer self-disclosure are very similar to those noted above that can occur in the counseling relationship, but public

and media disclosures can be more complicated. I have had many experiences with the media, some quite positive and others that I thought would be at a PBS level that turned out to be closer to tabloid TV. The problems related to media are numerous and include programs that:

- victimize clients by emotionally exploiting their pain to elevate viewer, listener, or reader ratings;
- undermine personal recovery by asking questions that, if answered, would violate recovery support group membership guidelines (e.g., A.A. Traditions);
- contribute to stigma by focusing on sensational aspects of addiction that inflame fear and prejudice while failing to tell the recovery story fully;
- misrepresent by omission or distortion treatment methods and scientific data on treatment outcomes; and
- misrepresent by omission or distortion the diversity of pathways to recovery.

Participating in such practices undermines rather than elevates the field's service mission. Counselors also need to avoid serving as intermediaries in enticing clients to participate in media exposure primarily intended for purposes of program marketing.

Up in Smoke: Tobacco Addiction and the Addictions Professional

No ATOD-related issue generates more emotion right now than the issue of smoking as a professional practice issue or proposals for changes in organizational smoking policies in addiction treatment institutions. The nexus between personal nicotine addiction and professional performance is so great that smoking for those working in prevention and treatment will likely become a tragic and ironic artifact within the history of the field. The evidence supporting this shift is overwhelming.

The Factual Case Against Tobacco

1. 60 million Americans are addicted to tobacco (McGinnis & Foege, 1999).
2. 446,000 Americans die each year of tobacco-related diseases, compared to 105,000 from alcohol abuse and alcoholism and 39,000 from other addictive drugs (McGinnis & Foege, 1999).
3. Early onset of smoking and heavy smoking are highly correlated with the subsequent development of other substance use and psychiatric disorders (Degenhardt & Hall, 2001).
4. Heavy smokers have more severe substance use disorders than do non-smokers and more moderate smokers (Marks, Hill, et al., 1997; Krejci, Steinberg, et al., 2003).
5. Between 85% and 95% of people admitted to addiction treatment in the United States are dependent upon tobacco—more than triple the national average (Bobo,1992; Abrams et al., 1996; Burling & Ziff, 1988).
6. People with alcohol problems exhibit more severe nicotine addiction than do smokers without alcohol problems (Batel, Pessione, et al., 1995; Toneatto, Sobell, Sobell, & Kozlowski, 1995), are less likely to stop smoking (Hays, Schroeder, et al., 1999), and, as a result, bear a greater burden of nicotine-related diseases and deaths.
7. Those with more severe nicotine dependencies have poorer outcomes for the treatment of other drug dependencies (Patkar, Vergare, et al., 2003; Hillemacher, Bayerlein, et al., 2006); continued smoking following treatment for other drug dependencies increases the risk of relapse (Sobell, Sobell, & Kozlowski, 1995).
8. In alcoholism treatment programs in which smoking is not addressed, smoking cessation rates are very low (e.g., 3%) following discharge from treatment (Sobell, Sobell, & Agrawal, 2002).

9. Smoking-related diseases are a major cause of death for people who have successfully recovered from alcoholism/other drug dependence. Of those discharged from alcoholism treatment, more will later die from nicotine-related diseases than from alcohol-related diseases (Hurt et al., 1996).
10. The development of nicotine dependence by non-smokers during and following addiction treatment may constitute a harmful side-effect of such treatment as it is currently designed (Friend & Pagano, 2004).
11. Staff perceptions that most people admitted to addiction treatment do not want to stop smoking are challenged by surveys finding that most patients have a desire to stop smoking (Irving, Seidner, et al., 1994; Joseph, Nelson, et al., 2003), including those with co-occurring psychiatric illnesses (Unrod, Cook, et al., 2004).
12. Recovery rates are not compromised (and in fact are enhanced) when nicotine addiction is treated concurrently with other addictions (Bobo, McIlvain, et al., 1998; El-Guebaly, Cathcart, et al., 2002; Joseph, Nichol, et al., 1993; Lemon, Friedmann, et al., 2003; Sees & Clark, 1993).
13. Smoking cessation interventions provided during addiction treatment increase the rates of long-term abstinence from alcohol and illicit drugs by as much as 25% (Stuyt, 1997; Prochaska, Delucchi, et al., 2004).
14. Recovery from alcoholism increases the probability of successful cessation of nicotine addiction (Breslau & Peterson, et al., 1996).
15. No-smoking policies in addiction treatment programs do not decrease admissions or increase discharges against medical advice or administrative discharges (Hurt & Slade, 1990).
16. The scientific evidence overwhelmingly supports encouraging and assisting smoking cessation for individuals in recovery from other addictions (Sees & Clark, 1993; Sussman, 2002).
17. Staff members who continue to be addicted to nicotine constitute a major obstacle to the reform of smoking policies in addiction treatment programs and the revamping of clinical philosophies and procedures related to nicotine addiction in such settings (Psychiatric News, August 4, 2000; Falkowski, 2003).[6]

Moving forward to address nicotine addiction within the larger rubric of addiction treatment is no longer a question of inadequate research; it is a question of honesty, courage and leadership.

Every day, addictions professionals who have been addicted to nicotine are shedding that addiction and embracing a personal manifesto containing one or more of the following propositions.

Nicotine: A Personal Manifesto	
I choose to:	**I refuse to:**
Forever sever my personal relationship with nicotine; it no longer has a place in my life.	Contribute money to or accept money from a predatory industry that has consciously sacrificed the health of the public for corporate profit.
Help hasten the end of the addiction field's enabling of tobacco addiction among our clients and our workers.	Remain silent about the tobacco industry's targeted marketing to women, children, communities of color, and citizens of developing countries.

[6] I would like to acknowledge the assistance of Jason Schwartz in conducting this literature review.

Model responsible decision-making regarding all psychoactive drugs and encourage my clients and peers to do the same.	Model a behavior (smoking) that could take years from my own life and the lives of those who could be influenced by my example.
Offer assistance to those seeking to recover from nicotine addiction.	Live the hypocrisy of being addicted while working as an addictions professional.

Guidelines for ATOD Decision-making

ATOD use by addictions professionals is an issue with a long history that continues to be marked by complexities, ambiguities, and a lack of professional consensus. It remains an issue that can rapidly explode, injuring professional careers, service consumers, service organizations, and the broader professional arena in which we work. For the past four decades, I have been called upon to offer advice to individuals and organizations regarding these issues. The wisdom drawn from the history of the field and from my experience as an elder in this field is best summarized in the following guidelines. I offer them with a deep appreciation that others may extract different lessons from this history, and that lessons learned from the experiences of one generation may or may not be applicable to the changing contexts of the next.

1. Respect the fishbowl effect that accompanies work in all status- and stigma-laden fields. Remain cognizant of how your behavior in "off hours" influences the ways in which you and your organization are perceived within your community, and how such perceptions influence policy makers and current and potential service consumers.
2. As a professional leader, seek not a life of perfection, but a life of reasonable congruence between the field's core values and your daily conduct. Leaders and visible members of social movements involving stigmatized social issues have no rights to privacy, only decisions and behaviors that help or hurt their causes.
3. Filter decisions related to disclosure of your ATOD use history, your recovery status, and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth), discretion (protect your privacy), and, for those in Twelve Step recovery, the tradition of anonymity at the level of press.
4. If you are in recovery, cultivate and sustain mechanisms of recovery maintenance separate from your professional life. Working in service roles within the addictions field is not a viable program of personal recovery and may even undermine defense structures that have previously served to maintain sobriety.
5. Rigorously evaluate your own past or current relationships with ATODs, their role in your decision to work in the addictions field, and the congruence or incongruence between those relationships and your service responsibilities. Filter your ATOD use decisions through those ethical values that have long guided professional service relationships: competence, honesty, fidelity, loyalty, non-malfeasance, and self-interest.
6. Use your personal/family ATOD-related history and your broader life experiences to enhance mutual identification and acceptance in the service relationship, convey hope and encouragement, and model skills essential to recovery self-management. Exemplify as best you can such core recovery values as self-acceptance, honesty, humility, gratitude, forgiveness, tolerance, and service.
7. If you drink alcohol, use discretion related to when, where, and under what circumstances you drink; the amount you drink; and how you conduct yourself while drinking ("the night has a thousand eyes"). If you drink alcohol, drink within the limits of healthy drinking established

by the National Institute on Alcohol Abuse and Alcoholism[7], and NEVER, NEVER drive after having consumed ANY alcohol.

8. If you work within an organizational culture that promotes excessive ATOD consumption, cultivate an outside-of-work support system to neutralize the influence of that culture, develop a sobriety-based support network within this setting, and explore relocation to a healthier organizational environment.
9. If you are consuming over-the-counter or prescription drugs with psychoactive effects or side effects, communicate this status to your clinical supervisor and/or a trusted professional peer, with the request that they help monitor your performance for any untoward effects.
10. If you are in recovery and have resumed ATOD use, you have a professional responsibility to immediately report this change in status to your clinical supervisor; evaluate the effect of this changed status on your clinical performance; and seek immediate help to prevent future harm to yourself, your clients, your organization, and the integrity of the field.[8]
11. If you wish to return to the field after having relapsed while working as an addictions professional, your chances are best if you demonstrate your willingness to meet the highest standards of supervision, e.g., your willingness to: 1) re-enter the field on a probationary status, 2) accept any requested limitation of duties, 3) participate in a formal impaired professionals treatment program, 4) provide random urine drops, 5) provide verification of counseling participation, 6) provide verification of participation in recovery mutual aid meetings, and 7) have a professional peer mentor.
12. If you are using illicit drugs, evaluate the potential effects of such use on those to whom you are personally and professionally accountable. If you value such use more than those to whom you are professionally accountable, seek an expert evaluation of your relationship with these substances or seek employment outside the specialty addictions field. Failure to take those actions is a violation of your fiduciary pledge to this field and the needs of its service constituents.
13. Adhere to all current legal, professional, and organizational standards related to ATOD use.
14. Immediately declare to your supervisor any pre-existing relationship with a potential or admitted client (or a client's family member) with whom your past AOD use or related activities could affect the client's feelings of safety and comfort receiving services at your organization.
15. Remain cognizant of how your reasons for using ATOD influence your attitudes toward, relationships with, and biases related to treatment goals and methods for each client. If you abstain from ATOD, remain aware of the ways in which either the reasons for that abstention or your particular pathway and style of recovery might positively and negatively influence your work with clients, professional peers, and the community. Use clinical supervision to identify negative transference and countertransference before such feelings are acted out destructively by you or your client.
16. If you are addicted to nicotine and working as an addictions professional, you have a responsibility to initiate and sustain recovery from that addiction, and to keep seeking personal/professional support until that goal is achieved permanently.
17. Disclose your past or present ATOD experiences and decisions with clients only if that disclosure is clinically strategic, brief, appropriate for the developmental stage of the service relationship, and restricted to past material over which you have emotional control.
18. Beware of stigma pimps from the media who exploit stereotypes and fear for their own personal glorification and profit. Take risks with self-disclosure at the level of press only with individuals and programs that have an established track record of professionalism and respect.

[7] The NIAAA standard is for women to drink no more than one drink per day (total of seven drinks per week) and for men to drink no more than two drinks per day (total of fourteen drinks per week) (Dufour, 1999).

[8] This is not an arbitrary standard applied to those in recovery. I have argued elsewhere (White & Popovits, 2001) that any change in one's personal life that could significantly affect one's clinical work should be reported and processed in clinical supervision.

The ultimate mandate for addictions professionals is to conduct their personal and professional lives in a manner congruent with the service mission they have chosen. These suggestions are offered, not as the last word on this subject, but as a stimulus to future dialogue on this important professional practice issue.

In closing, I also find it important to note what I have chosen not to address in this essay. The boundaries of the concept of addiction have eroded considerably, both in the addictions field and in the popular culture. At a professional level, an ever-widening range of excessive relationships with work, money, food, sex, risk, religion and the Internet are being embraced within the rubric of addiction. In the latter, people speak of being addicted to everything from chocolate to golf. This over-extension of addiction from its precise biological origins to its use as a broad metaphor for behavior that is pleasurable, repetitive, and potentially life disrupting, while troubling and perhaps inevitable, has important implications for the future of professional practice in addiction counseling.

There will likely be a growing movement to expand the range of historically private behaviors regarding which those working in the addictions field will be held professionally accountable. When does a counselor weigh too much or too little to work in addiction treatment? When does an addiction counselor's visit to a casino on his or her own time become a professional practice issue? Does the counselor working 60 hours a week deserve an award for this behavior or an admonishment and referral to the employee assistance program? The list is potentially unending, and that is the point.

Professional service fields tend to mirror the problems of their service consumers. Yes, the addictions field has a historical propensity for black-white thinking and excessive behavior! We will need to manage this propensity actively if the conceptual boundaries of addiction continue to erode. Defining the nexus—the point of connection—between private behavior and professional performance will be a difficult task as the field continues to evolve and redefine itself.

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Citation: White, W. & Syrcle, J. (2008). Evaluating the "hard core drinking driver." Addiction Professional, 6(1), 18-23.Posted at **www.williamwhitepapers.com**

Evaluating the "Hard Core Drinking Driver"

William L. White. M.A. & Joy Syrcle, M.A.

Alcohol-related fatalities have significantly decreased over the past 25 years, but alcohol-impaired driving continues to kill more than 17,000 individuals per year—40% of all traffic fatalities (NHTSA, 2005). Sustained public education campaigns and toughened laws have led to dramatic decreases in the number of social drinking drivers. As the pool of social drinking drivers decreases, "hard core drinking drivers" constitute a larger portion of the impaired driving offender population (Simpson & Mayhew, 1991). States have called upon addiction professionals to evaluate those arrested for impaired driving to identify such high risk drivers, but the accuracy of these evaluations has often been compromised by reliance on self-report data and imperfect evaluation instruments. Particularly troublesome is the fact that the percentage of retrospective alcohol dependence diagnoses triples when impaired drivers are re-evaluated five years following their first arrest (Lapham, C'de Baca, McMillan, & Hunt, 2004). This article describes efforts in the State of Illinois to enhance the quality of such evaluations and highlights a recent study that sheds light on the profile of the hard core drinking driver.

Impaired Driving: One State's Response

Illinois has a long history of collaboration across multiple agencies to reduce alcohol-related driving fatalities. Between 1982 and 2001, toughened laws, assertive law enforcement and prosecution, an informed judiciary, assertive monitoring by probation officers, rigorous gatekeeping of licensure re-instatement by Secretary of State administrative hearing officers, as well as mandated professional evaluation and treatment contributed to a 60% reduction in Illinois' alcohol-related fatalities (National Highway Traffic Safety Administration, 2002). Even in the face of such success, calls grew for a more sophisticated approach to the evaluation and management of the state's driving under the influence (DUI) offenders.

Historically, evaluators have been asked to answer three questions related to the DUI offender: 1) Does this offender have a problem in his or her relationship with alcohol and/or other drugs? 2) If so, what is the duration and level of severity of this problem? 3) What combination of educational and treatment services has the greatest probability of resolving these problems? While such questions are appropriate in the context of addiction

treatment, they do not, in and of themselves, answer two broader questions: 1) What degree of risk does this offender pose to the safety of the public (risk defined as DUI recidivism and future involvement in alcohol-related crashes involving damage to property, personal injury, and death)? 2) What community strategies can be best combined to lower the threat to public safety posed by this offender?

In an effort to provide better answers to these questions, the Illinois Department of Transportation, in collaboration with the Administrative Office of Illinois Courts, the Division of Alcoholism and Substance Abuse, and the Illinois Secretary of State, created a DUI Task Force and a Risk Reduction Work Group. The latter group was charged in 2000 with the responsibility of examining the DUI evaluation process in Illinois. The work of this committee was performed under the direction of the Institute for Legal and Policy Studies at the University of Illinois. Over the ensuing years, the Risk Reduction Work Group: 1) conducted a literature review of the DUI evaluation process (White, 2004), 2) created a scientific advisory panel, 3) conducted a 2001 national survey of state DUI evaluation processes/instruments (47 states provided survey responses), and 4) conducted focus groups with Illinois' prosecutors, judges, probation officers, evaluators, treatment specialists, and administrative hearing officers.

There were two major findings from these early steps. First, we found that states varied widely in their evaluation protocol. There were differences in which state agency was responsible for alcohol-related public safety, who conducted the evaluation of DUI offenders (e.g., private contractor versus probation officer), and DUI evaluation instruments. Twenty-three of 47 states mandated use of one or more instruments, with DRI-II and the Mortimer-Filkins being the most commonly mandated evaluation tools. In the national survey, we found a total of 33 evaluation instruments in use with only half the states reporting that they were satisfied with the instrument they were using.

Second, multiple stakeholders shared with us concerns that the integrity of DUI evaluations was being compromised by reliance on self-report, inconsistent access to criminal and driving/insurance records, and instruments that did not collect critical areas of information (e.g., histories of drug use other than alcohol). There was also concern in those states in which DUI evaluation was the province of the private sector that competition for defense attorney referrals downgraded the rigor of the evaluation process (i.e., those agencies with reputations for rigorous assessment not getting referrals). There was a particular concern that existing evaluation instruments/processes did not identify those offenders who posed the greatest threat to public safety and who should receive the greatest intensity of supervision resources. This led the Work Group to identify those qualities of an ideal evaluation instrument and to explore whether any existing instrument met those criteria.

When the Risk Reduction Work Group found no instruments that met all the desired criteria for an evaluation instrument, the group identified the instrument—The Adult Substance Use and Driving Survey (ASUDS)—that met the most of such criteria and contracted with its developers (Drs. Ken Wanberg and David Timken) to modify the instrument to include additional data collection elements desired by Illinois DUI stakeholders. The revised instrument (ASUDS-RI) (Revised for Illinois) was then piloted in 2004 with 486 offenders in 10 different evaluation sites.

The ASUDS-RI (Revised for Illinois) is a self-administered assessment instrument composed of 113 questions arranged into 15 scales and sub-scales. The scales are designed based on research related to DUI risk and risk prediction. Scales related to drug use and criminal history were added or modified for the Illinois version of the instrument based on the feedback received from multiple DUI constituency groups. The scales include the following:

- *Alcohol Involvement*: Measures the extent of alcohol use.
- *Driving Risk*: Evaluates general risk-taking behavior while driving.

- *Antisocial*: Assesses antisocial behavior and attitudes.
- *Mood Disruption*: Measures depression, anger, and/or anxiety problems.
- *Alcohol/Drug Involvement*: Measures drug use across 10 major categories.
- *Disruption*: Measures the problems/consequences encountered by the respondent as a result of drugs or alcohol; identifies symptoms of abuse or dependence.
- *Involvement/Disruption One-Year*: Measures the scope and intensity of alcohol and drug use and negative consequences related to such use in the past 12 months.
- *Global*: A composite of Involvement, Disruption, Anti-social, and Mood Disruption scales that provides an overall risk profile for each offender.
- *Motivation*: Measures the degree to which the respondent is willing to make necessary changes related to alcohol or drug use.
- *Benefits*: Utilizes components of the Involvement scales to measure social or psychological benefits gained from use and self-treatment of depression or anxiety.
- *Antisocial (community)*: Sub-scale of Antisocial. Identifies general attitudes linked to anti-social behavior.
- *Antisocial (criminal justice)*: Sub-scale of Antisocial. Measures past and current involvement with the criminal justice system.
- *Psycho-social Disruption*: Sub-scale of Disruption. Measures physical and psychological problems related to alcohol or drug use.
- *Social-behavioral Disruption*: Sub-scale of Disruption. Identifies social problems such as inability to work and problems with family resulting from use.
- *Defensiveness*: Measures the degree to which the respondent is willing to disclose sensitive information.

The output from the instrument provides a raw score for each scale and a percentile rank showing where the respondent falls in relation to other DUI offenders and a composite score with cut points indicating the level of service needed.

A major goal in refining the ASUDS-RI was to develop an instrument that could differentiate first time DUI offenders who are unlikely to be involved in future DUI offenses from the first time DUI offender whose problems are likely to escalate into increased risk of DUI recidivism and alcohol/drug-related crashes. We will use this Phase One pilot data from Illinois to illustrate growing understanding of the Hard Core Drinking Driver (Syrcle & White, 2006).

The Hard Core Drinking Driver

The hard core drinking driver (HCDD) is an individual who, following repeated sanctions, continues to drive at least once a month with a BAC of 0.15% or greater (Simpson, Beirness, Robertson, Mayhew, & Hedlund, 2004). Such drivers make up a small subset (about 3%) of licensed drivers, but contribute 80% of the total impaired driving trips (Beirness, Simpson, & Desmond, 2003). Due to the frequency with which they drive while impaired and the degree of that impairment, HCDDs pose a very significant threat to public safety. One of the tasks of the addiction professional serving as a DUI evaluator is to recognize the HCDD and recommend interventions that can lower this threat to public safety.

An emerging HCDD profile is emerging from multiple studies that compare DUI non-recidivists with DUI recidivists (Summary data below is from White & Gasperin, in press). Several components dominate that profile and are illustrated by the Illinois ASUDS-RI data.

Recidivist Demographic Profile: As a group, DUI recidivists are predominately single, separated, or divorced Caucasian or Hispanic males between the ages of 25-45. They have less than 12 years of education, are transiently employed in blue collar jobs, and are part of social groups whose members are heavy drinkers and drinking drivers. In the Illinois pilot study, repeat offending peaked between the ages of 31-

35, and the repeat offenders were more likely than non-recidivists to be married or divorced. The fact that recidivism risk declines with age suggests the need to mobilize community resources to contain the HCDD until they age out of this high-risk pattern.

Driving Attitudes / History: Compared to the non-recidivist, the DUI recidivist is more likely to believe that he or she can drive safely after drinking and to see his or her DUI arrest as a function of bad luck or police harassment. They are also more likely to have past histories of high risk driving (e.g., failure to wear seatbelts, moving violations, accidents, injuries) (Begg, Langley, & Stephenson, 2003). In the Illinois pilot, recidivists were more likely to have prior arrests for speeding, failure to yield/stop, improper lane usage, seat belt, or child safety violations as well as being nearly twice as likely as first-time offenders to have at least one prior collision on their driving record.

Substance Use / Treatment History: DUI recidivists are distinguished from non-recidivist offenders by an increased propensity for family histories of alcohol- and other drug-related problems. Many recidivists reported early exposure to drinking and driving by their parents and adolescent exposure to drinking and driving within their peer social group. They are also more likely to report early age of onset of alcohol, tobacco, and other drug use. In the Illinois pilot, recidivists were more like to be heavy smokers (1-2 packs a day), less likely to have successfully quit smoking, and reported greater number of episodes of past illicit drug use. Multiple offenders were substantially more likely to have previously attended treatment and, to a lesser extent, self-help groups—a factor likely influenced by mandated treatment or Alcoholics Anonymous exposure linked to earlier DUI arrests. Although not tested in the Illinois pilot, research reviews note that recidivists are more likely to have dropped out of prior treatment and to have failed to complete earlier court-ordered services (White & Gasperin, in press).

Arrest Event: DUI arrests of recidivists, when compared to non-recidivists, were more likely to be characterized by a high BAC (greater than .15) without gross signs of intoxication, collateral charges, and refusal to take a Breathalyzer test. Over half (55.6%) of the DUI recidivists in the Illinois pilot study refused the breathalyzer test, compared to only 30% of first-time offenders. Even with this high rate of refusal, the remaining recidivists still had a significantly higher BAC (mean of .159) (as well as self-reports of drinking more hours and more drinks) than first time offenders. Recidivists were also more likely to have been arrested on Monday, Wednesday, and Thursday. It is unclear why the trend toward an increased likelihood for repeat offender arrests during non-weekend nights does not hold true for Tuesday, unless this reflects a pattern of brief reprieve among daily, heavy drinkers whose consumption peaks over the course of extended weekend drinking episodes.

Criminal History: Those with one or more prior DUI offenses are significantly more likely to have a prior non-DUI arrest on their criminal history report than first-time DUI offenders. Nearly half of the multiple offenders have two or more prior non-DUI arrests, compared to less than 20% for first-time offenders. Nine percent of repeat offenders have five or more previous non-DUI arrests. Multiple offenders had a history of crimes against persons at a rate twice that of the first-time offenders; 30% and 15% respectively. In addition, the person crimes of repeat offenders were more likely to be domestic violence related, with 56% of the person crimes for multiple offenders being for domestic violence. The difference between first-time and repeat offenders is less pronounced in terms of previous charges related to controlled substances, with rates of 11% and 19% respectively. The over-representation of cannabis and controlled substance violations in the multiple offender group is consistent with the finding that multiple offenders are almost three times more likely to have a collateral charge of cannabis possession at their DUI

arrest than are first offenders (9% compared to 3.2% respectively).

Characterological Profile**:** DUI recidivists are more likely than non-recidivists to have prior treatment for psychiatric illness as well as medical treatment reflecting injury to self via risk-taking. Recidivists are also distinguished by diminished capacity for empathy, a marked absence of guilt and remorse, a failure to take personal responsibility for decisions and their outcomes, and a general pattern of impulsivity and risk-taking (White & Gasperin, in press). Evaluation instruments like the ASUDS-RI that focus on global assessment will increase our ability to identify such characterological risk factors and tailor particular interventions to address them.

The Future

The ASUDS-RI pilot study was able to obtain completed evaluations on 486 individuals and analyze the evaluation data to establish Illinois norms for the ASUDS-RI. The pilot study also added information on the profile of the Illinois DUI offender and DUI recidivist population. This preliminary study confirms a number of risk factors for DUI recidivism that have been noted in the national profile literature: gender (male), age (21-45), marital status (never married or divorced), less stable employment, prior treatment, prior non-DUI criminal history, prior criminal history of violent aggression, prior non-DUI traffic offenses, breathalyzer refusal or high BAC, and more likely to be arrested for DUI on a Monday, Wednesday or Thursday. Of the 16 ASUDS-RI scales, 14 of these scales revealed significant differences between the fist-time DUI offender and the multiple-DUI offender.

Continued follow-up of this and other populations of DUI offenders will reveal increasingly precise delineations of those factors that predict DUI recidivism and broader threats to public safety. Once we have defined this highest risk population of impaired drivers, it may be possible to develop specialized treatment protocols designed to enhance their recovery rates and lower their threat to communities across the country.

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Citation: White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. Counselor, 9(1), 38-43. Posted at **www.williamwhitepapers.com**

Toward a Philosophy of Choice: A New Era of Addiction Treatment

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Being given choices of institutions, levels of care, treatment goals/methods, service personnel, and service duration has historically not been part of the personal experience of addiction treatment in the United States. This article describes why addiction treatment professionals have been reticent to offer choices to their alcohol and drug dependent clients and why that philosophy is now undergoing reevaluation.

Dr. Jekyl and Mr. Hyde

Addiction treatment has for more than 150 years been more a process of professional diagnosis, direction, and indoctrination than a process of guided self-reflection and self-change. Since the advent of program accreditation standards in the 1970s, clients entering addiction treatment have been asked to sign a treatment plan. This ritual has conveyed the illusion of participation and choice, but anyone familiar with the process knows that the choices available to clients have, until recently, been narrowly prescribed by each program's treatment philosophy, available levels of care, coercive dictates from referral sources, or by the external care managers who governed reimbursement decisions. Another factor concerning limited choice in addiction treatment is the perception that those entering addiction treatment have lost the power of choice—that the state of addiction is the very antithesis of choice (Michael Flaherty, personal communication).

Slogans heard within traditional treatment and recovery circles suggest that people addicted to alcohol and other drugs:

- Possess an elaborate cognitive defense structure (grandiosity, denial, minimization, rationalization, intellectualization, projection of blame, preoccupation with power and control) that seriously distorts reality and undermines decision-making (e.g., *Utilize, don't analyze*, *Identify, don't compare*).
- Are incapable of honest self-perception and complex choice-making (e.g., *When you think you're looking good, you're looking bad*;

Your best thinking got you here; *Keep it simple, stupid*; *First thing's first*).

- Cannot be relied upon to act in their own best interests (e.g., *An alcoholic is someone who finds something that works and then stops doing it*; *The three most dangerous words for the alcoholic—I've been thinking*).
- Best enter recovery through a process of submission and surrender (e.g., *Let go, Let God*; *Sit down, shut up, listen*; *When in doubt, act as if*; *Fake it 'til you make it*).

The problem with choice for the alcoholic/addict has often been framed as a problem of the split self. The question is, "Who's really choosing: Dr. Jekyll or Mr. Hyde?" How can we as professionals distinguish a client's authentic choice from what A.A. calls "stinkin' thinkin'", what Rational Recovery calls the addictive voice or "Beast," what Secular Organization for Sobriety refers to as the "lizard brain," what LifeRing Secular Recovery calls the "addict self" (versus the "sober self"), and what Christian recovery groups sometimes refer to as the "voice of the Devil"? If we offer each client enhanced choices, will it be the client or the disorder/devil making the decisions?

This treatment and recovery folklore has gained credence from recent scientific studies. In May 2007, Dr. Nora Volkov, Director of the National Institute on Drug Abuse, presented a historic lecture at the annual APA conference entitled the "The Neurobiology of Free Will" that signaled a turning point in the field's understanding of addiction as a brain disease. Dr. Volkov described the most complex picture to date of how drugs compromise multiple regions of the brain in ways that place continued AOD use as a priority over other best interests of the individual, family, and society (See also Nature Neuroscience, 2005). Based on the work of Volkov and other scientists, one could posit addiction as a disease of the will marked by a progressive loss of volitional control over AOD use and related decision-making. Unfortunately, work to date reveals very little about the neurobiology of recovery. There is much talk of hijacked brains (e.g., the erosion of executive function, the loss of inhibitory control, re-ordered motivational priorities), but the extent and timing of the reclamation of the will through the recovery process remains shrouded in mystery. Studies to date (e.g., Bartsch, Homola, Biller et al., 2007) show a good prognosis for brain recovery associated with abstinence, but questions abound regarding the pace and extent of such recovery.

The Context for Choice

The factors limiting client choice in addiction treatment now face countervailing forces. The options available to those with AOD problems have never been greater, as reflected in the number of specialized and competing addiction service organizations, the availability of brief interventions, numerous evidence-based treatments (including new pharmacotherapies), the growth and diversification of addiction recovery mutual aid groups (including explicitly religious and secular alternatives to Twelve Step Programs), the availability of peer-based recovery support services, and the growing availability of Internet-based services (Humphreys, 2004; White, 2004; White, in press). There is also growing scientific evidence that many people resolve AOD problems without professional or peer assistance (Cunningham, Sobell, Sobell, et al, 1995; Granfield & Cloud, 1995). Today, individuals and families seeking help have choices that vary widely in setting, philosophy, service elements, service personnel, and costs.

There is growing awareness of the legitimacy of multiple pathways and styles of long-term recovery (White & Kurtz, 2006b). A new recovery advocacy movement is calling upon individuals and families to take responsibility for their own long-term recovery processes and to promote pro-recovery social policies and recovery-oriented systems of care (White, 2006). The need for informed consumers of addiction treatment is underscored by historical and scientific findings that:

- "Harm done in the name of help" has a long tradition in the history of addiction treatment (White, 1998).
- Many current mainstream treatment practices lack scientific evidence of their effectiveness, and others have been shown to be potentially harmful (Miller, Wilbourne, & Hettema, 2003; White & Miller, 2007).
- Treatments utilizing different philosophical foundations and therapeutic techniques can generate comparable treatment outcomes for adults (Project MATCH Research Group, 1998) and adolescents (Dennis, Godley, Diamond et al., 2004), but individual treatment programs and individual counselors vary widely in their recovery outcomes (McLellan, Grissom, Brill et al., 1993; McLellan, Woody, Luborsky, & Goehl, 1988).
- Responses to all recovery mutual aid groups vary, including individuals who fully respond, partially respond, and fail to respond (Morgenstern, Kahler, Frey, & Labouvie, 1996)—a finding that reinforces the importance of person-program fit.
- Client motivation and transfer of learning from therapeutic to natural environments is enhanced by client choice in the treatment and recovery support process (Miller & Rollnick, 1991).
- When given a choice, individuals tend to choose the goal that is most appropriate for them (Larimer et al., 1998).

The movement to expand client choice-making in addiction treatment is also being fueled by the development of new service technologies (e.g., motivational interviewing, contingency management, recovery coaching) that provide frameworks for facilitating client choice and the use of special aids to enhance recovery-conducive decision making (e.g., from pharmacological adjuncts to sustained professional and social support). It is in this context of expanded service options and new strategies for managing choice that calls are increasing to redefine the relationship between addiction professionals and those they serve from an expert relational model to a partnership-consultant model that provides stage-appropriate guidance and support (White, Boyle, & Loveland, 2002). And yet the question remains, "Would promoting expanded choices put clients in the driver's seat when, according to some therapeutic philosophies, that is exactly the position they need to abandon?"

Choice and the Stages of Recovery

One way to partially reconcile the dilemma between the traditional and emerging views of choice is to first acknowledge that free will in addiction and recovery is not an all or none phenomena. The capacity for volitional control over AOD use and related decisions is variable across individuals (as a function of the interaction between problem severity/complexity and recovery capital) and is dynamic (shifts incrementally on a continual basis within the same individual through both addiction and recovery processes). Recovery can be viewed as progressive rehabilitation or reclamation of the will—the power to reclaim personal choice (Smith, 2005). There are times the recovery process may involve consciously not choosing—relying on resources and relationships outside the self, and times that the next recovery steps require an assertion of self. At a practical level, this means that the first hours of acute detoxification are not the best time to rely exclusively on client choice. And yet long-term recovery is not possible without choice. If there is no rehabilitation of the power to choose and encouragement of choice, we are left with, not sustainable recovery, but superficial treatment compliance.

To effectively apply a philosophy of choice requires great skill on the part of the addiction professional, particularly where a client's immaturity, cellular craving, impulsivity, psychiatric symptoms, and impaired judgment severely limit choice generation, choice analysis, and the

capacity to stick with any personal resolution. In such cases, we must carefully plot a path between complete autonomy (total choice and clinical abandonment) and paternalism (no choice and intrusive control). Most clients have a sense of this need as well. Studies have shown that people with severe alcohol problems, perhaps recognizing their impaired decision-making capacities, prefer therapist-set goals in treatment, whereas those with less severe problems prefer self-set goals (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992). I suspect mismatches in the degree of choice allowed in the treatment process (both ill-timed episodes of too much and too little choice) contribute to high rates of treatment non-completion via clients leaving against staff advice and clients being administratively discharged.

Implementing a Choice Philosophy.

One of the most important arenas of choice within addiction treatment involves broad frameworks of recovery. The choice philosophy is based first on the recognition of multiple (secular, spiritual, and religious) pathways and styles of long-term recovery and the recognition of the right of each person to select a pathway and style of recovery that represents their personal and aspirational values. Steps that addiction treatment programs can take to actualize a philosophy of choice related to recovery pathways are illustrated in Table 1.

Table 1
Actualizing the Choice Philosophy Related to Recovery Pathways

- Addiction counselors, recovery coaches, and volunteers represent the diversity of pathways and styles of personal/family recovery.
- Addiction counselors and recovery coaches are knowledgeable about the full spectrum of religious, spiritual, and secular recovery support groups and can fluently express the catalytic ideas used within each of these frameworks.
- Addiction counselors and recovery coaches are aware of common patterns of co-attendance (concurrent or sequential participation in two or more recovery support structures).
- Individuals and their families are educated about the variety of recovery experiences and the legitimacy of multiple pathways and styles of recovery.
- Informational materials, lectures, and structured exercises that people receive represent the scope of recovery support options, e.g., posting all local recovery support meeting schedules on the treatment agency website and facility bulletin boards, giving each client a wallet card with the central contact numbers of local recovery support groups, profiling local recovery support groups in agency/alumni newsletters.
- Individual choice is respected; individuals receiving services are not demeaned or disrespected for the recovery support strategies they choose; clinical strategies involve motivational interviewing principles and techniques rather than coercion and confrontation.
- Addiction counselors and recovery coaches are encouraged to self-identify negative feelings they may have about a particular pathway of recovery chosen by a client and discuss such feelings in the context of clinical supervision. (Adapted from White & Kurtz, 2006a)

Creating Informed Consumers

A philosophy of choice is viable only with persons who have the neurological capacity for decision-making, who believe they have the right to make their own choices, and who are aware of and can evaluate available service and support options. Creating informed, assertive consumers of addiction treatment and recovery support services can be enhanced by: 1) affirming the service consumer's right

to choose, 2) distributing and reviewing consumer guides on treatment and recovery support services published by local recovery advocacy organizations, 3) teaching service consumers how to recognize quality treatment services and healthy support groups, 4) informing consumers about the potential of harmful side effects of treatment and mutual aid group participation, 5) encouraging consumers to visit and sample service/support options, 6) defining the criteria by which the client and service specialist will know if participation in a particular activity is working or not working, and 7) monitoring each client's responses to treatment and support services (Bev Haberle, Personal Communication, 2007). Similar considerations need to be extended to educate the family members of those needing or seeking recovery.

Choice and Limited Resource Alternatives

A major obstacle to implementing a choice philosophy remains the limited recovery support options available today within many communities. Altering that situation requires moving from a clinical perspective to a recovery community development perspective. Recovery options are expanding, clients are using these options (either alone or in patterns of co-involvement with one or more support groups), and progressive treatment organizations are playing a role in nurturing the development of expanding recovery support resources (White, 2007). The internet is also bringing expanding treatment and recovery support services into many previously resource deficient communities. The choice philosophy only has meaning where legitimate alternatives exist for treatment and recovery support.

A Closing Reflection

A day is coming when each client seeking help for the resolution of AOD problems will be given a menu of service and support options. This menu will include the best scientific evidence drawn from national and international studies on the degree of effectiveness of the respective menu options. When that day arrives, each client, family, and referral source will also have the right to review standardized, recovery-focused performance measures for each treatment institution, each method of treatment, and each addictions professional. Our struggles today with the question of choice may mark the dawn of that coming day.

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Acknowledgement: Portions of this article have been excerpted/adapted from White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: Institute for Research, Education and Training in Addictions. A free download or purchase of a hard copy of this monograph is available at http://www.ireta.org/store/customer/home.php?siteversion=ireta.

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Citation: White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals. *Counselor*, 9(6), 10-17. Posted at **www.williamwhitepapers.com**

Preventing Harm in the Name of Help: A Guide for Addiction Professionals

William L. White, M.A. and Herbert D. Kleber, M.D.

"The history of medicine demonstrates repeatedly that unevaluated treatment, no matter how compassionately administered, is frequently useless and wasteful and sometimes dangerous or harmful. The lesson we have learned is that *what is plausible may be false and what is done sincerely may be useless or worse."* --Enoch Gordis, Director of the National Institute of Alcohol Abuse and Alcoholism, 1986-2001 (Gordis, 1987, p 582).

I. Introduction

Inadvertent harm in the name of help is a persistent theme within the history of medicine. The potential for harm through the helping process is reflected in two medical terms: *iatrogenic* illness (injury to patients resulting from medical treatment) and *nosocomial* illness (injury to patients occurring during institutional treatment). Originally focused on physicians and hospitals, these terms, particularly the former, have come to refer to harm that can occur from the actions or inactions of a broad spectrum of service professionals and the potentially untoward effects of diverse service environments (Caplan & Caplan, 2001). The term *iatrogenic* is most often used in the addictions literature to refer to drug addictions resulting from use of narcotics or other psychoactive drugs in the course of medical treatment (Musto, 1985), but this term also applies to the broader arena of inadvertent harm experienced by clients undergoing addiction treatment.

Individuals and families undergoing addiction treatment can respond positively (optimal and full problem resolution), partially (problem reduction without full resolution), neutrally (no measurable effect of treatment services), or adversely (clinical deterioration as a byproduct of the treatment intervention). Reviews of adverse reactions to addiction treatment reveal that 7-15% of clients exhibit worse in-treatment and/or post-treatment levels of problem severity and functioning than were evident at treatment admission (Moos, 2005).

Iatrogenic harm within addiction treatment potentially poses threats to multiple parties: clients and their families, addiction professionals, treatment organizations, the larger addictions treatment field, and local communities. Such broad vulnerability is the foundation of the special *fiduciary* relationship that exists between addiction professional and those they serve (White & Popovits, 2000). This essay: 1) reviews the history of iatrogenic and nosocomial injury within addiction

treatment from post-colonial America to contemporary addiction treatment, 2) highlights a few of the historical lessons from this review, and 3) proffers guidelines that can be used by addiction professionals to avoid injury to their clients, themselves and others to whom they are accountable. Harm in the name of help is an issue of concern in the broader alcohol and other drug problems arena, including prevention (Werch & Owen, 2002), research (Scott & White, 2005) and harm reduction programs (Kleinig, 2008), but our focus will be specifically on harm that can occur in addiction treatment and addiction counseling.

What Were They Thinking?

Treatments that were once though to cure alcoholism and other addictions include the disgusting and the whimsical. Alcoholics have been forced to drink their own urine, forced to drink wine in which an eel had been suffocated, and surreptitiously dosed with everything from mole blood to sparrow dung—all in the name of treatment and cure. Alcoholics have been subjected to the "Swedish treatment" where everything they drank and ate and even their clothes and bedding were saturated with whiskey. They have been put on every manner of dietary treatment—including the apple, salt, grape, banana, onion and watermelon cures (White, 1998). While the recounting of such treatments can elicit grimaces of disgust or smiles of amusement, there is a much more ominous side to this story.

Dr. Benjamin Rush is a pioneer in the recognition of chronic drunkenness as a medical disorder and was the first prominent physician calling for the creation of specialized institutions for the care of the inebriate. And yet he treated alcoholism with methods that included blistering, bleeding, switching alcoholics from distilled spirits to wine, beer and opium, and unknowingly poisoned his alcoholic patients with prodigious quantities of mercury-laden medicines. He was not alone. Treatment practitioners of the 19th century regularly treated alcoholics and addicts by prescribing alcohol, narcotics, cannabis, sedatives, stimulants, and other substances whose natures were never revealed. Private addiction cures were sometimes temporarily withdrawn from the market until their formulas could be changed following the deaths of patients (White, 1998).

Some early treatment practices are remarkable in light of subsequent knowledge. There was Dr. J.B. Bentley who in the 1870s and 1880s prescribed cocaine (by the pound) as a treatment for alcohol and morphine addiction and reported, as a testament to the effectiveness of this treatment, that his patients were requesting additional quantities of cocaine and that they had completely lost their appetite for alcohol and morphine (Bently, 1879). There was Dr. J.R. Black who in 1889 recommended that alcoholics be medically addicted to morphine on the grounds that morphine was cheaper, less physically devastating, and rendered the alcoholic less socially obnoxious. There was the published report of a physician, who after noting that alcohol intake decreased among his patients suffering active stages of gonorrhea, recommended medically infecting alcoholics with venereal disease as a way to save the expense of sanitarium treatment for alcoholism (Gonorrhea…, 1990). And there were early twentieth century "bromide sleep treatments" used to facilitate narcotic withdrawal in spite of reports that twenty percent of patients died during the procedure (Church, 1900; Kolb & Himmelsbach, 1938).

Such insults continued in the 20th century. At the height of the American eugenics movement, laws were passed that facilitated the mandatory sterilization of alcoholics and addicts (along with the mentally ill and developmentally disabled). The twin goals of sterilization were to reduce the underlying exciting causes of alcoholism and to prevent the conception of alcoholic progeny. The coerced sterilization of alcoholics, particularly alcoholic women, continued into the mid-20th century. Early 20th century therapies prescribed for other addictions included "serum therapies" that involved raising blisters on the addict's skin,

withdrawing the serum from the blisters, and then repeatedly injecting this serum during withdrawal. Some withdrawal therapies of the 1930s utilized “medicines” that could induce psychoses of up to two months duration (Kleber & Riordan, 1982; Reddish, 1931).

The 1940s and 1950s witnessed addiction treatments that included the use of electroconvulsive and insulin shock therapies as an aid to addict withdrawal, carbon dioxide therapies (with rare fatal side effects), and the experimental use of psychosurgery (the prefrontal lobotomy) as a treatment for alcoholism and narcotic addiction (Mason & Hambry, 1948; Talbot, Bellis, & Greenblatt, 1951; Thigpen, Thigpen, & Cleckley, 1955; Valenstein, 1986). This was followed by the use of apomorphine and succcinyl choline to induce an aversion to alcohol. The latter, when paired with drinking, produced an aversion to alcohol by temporarily paralyzing the respiratory system and inducing the terror of suffocation (Madill, Campbell, Laverty, & Vandewater, 1965). Methamphetamine was also used in the late 1950s as a medically prescribed substitute for addiction to alcohol and heroin. This practice served as a petri dish for the subsequent growth of a methamphetamine injection subculture in the 1960s (Kramer, Fischman, & Littlefield, 1967).

It is easy to look back on this brief review, shake our heads and ponder aloud how such so-called treatments could have ever come into existence and achieved even brief periods of professional legitimacy and social acceptance. But what of such harms in the modern history of addiction treatment?

Iatrogenic Injury in Addiction Treatment

Early Awareness of Iatrogenesis. When the modern field of addiction treatment came of age in the 1970s, it did so with an awareness that individuals and families could be harmed as well as helped by the actions or inactions of the new addiction treatment workforce. As a result, a number of protective mechanisms were built into mainstream treatment. These mechanisms included:

- Program licensure and accreditation standards that emphasized safety and professional practice protocol
- Procedures for informed consent prior to initiation of treatment services
- Confidentiality and privacy regulations
- Addiction counselor certification and licensure standards
- Addiction counselor codes of ethics, and
- Clinical supervision.

The further professionalization of the field in the 1980s and 1990s added additional mechanisms, such as college-based pre-service preparatory programs for addiction counselors, quality improvement programs, infection control programs, risk management programs, and Institutional Review Boards to govern research involving clients undergoing addiction treatment.

Prevalence of Iatrogenic Injury The rate of clinical deterioration (more severe AOD use frequency/intensity than pre-treatment levels) during and following addiction treatment ranges from 7-15% (Ilgen & Moos, 2005; Moos, 2005). In the single study that has evaluated psychiatric deterioration during addiction treatment, 13% of clients exhibited an exacerbation of psychiatric symptoms during treatment and as a consequence were more likely to use alcohol and drugs during treatment and to drop out of treatment (Ilgen & Moos, 2006). In the following discussion, we will explore the sources of such harm.

Harm from Flawed Theories: Defective theoretical formulations about the nature of alcohol and other drug problems have led to invasive and harmful interventions. For example, the mid-twentieth century theory that chronic alcohol and other drug intoxication was a superficial symptom of underlying psychiatric illnesses (e.g., a symptom of depression and not a

primary disorder) and that such symptoms would disappear with appropriate psychiatric treatment buttressed the use of prolonged psychiatric institutionalization, convulsive therapies, psychosurgery, and indiscriminant post-detoxification use of anxiolytic, sedative, hypnotic, stimulant and anti-psychotic medications as a treatment of addiction. Similarly, theories that addiction was a manifestation of anti-social personality disorder provided justification for mass incarceration of the addicted. Variations of that theory posited that persons addicted to alcohol and drugs possessed elaborate characterological armor that had to be dismantled before treatment and recovery could begin. That theory buttressed the use of verbal confrontation and "hot seat" techniques in the early history of therapeutic communities and Minnesota Model alcoholism treatment programs—approaches that have since been softened or abandoned (see White & Miller, 2007 on iatrogenic effects of confrontation in addiction counseling).

Harm from Errors in Diagnosis There are at least three types of injury that can occur during the screening and assessment processes conducted by addiction professionals. These include 1) false positives (diagnosing someone with a substance use disorder who does not have such a disorder), 2) false negatives (declaring there is no substance use disorder in an individual with such a disorder or misjudging and miscommunicating the severity of such a disorder), and 3) failure to recognize and respond to a collateral disorder or issue that is critical to long-term recovery.

Harm from false positives can occur when transient increases in alcohol and drug use that do not meet diagnostic criteria for a substance use disorder are diagnosed as a substance use disorder, resulting in a stigmatized diagnosis, the cost and life disruption of unneeded treatment, and other potential consequences ranging from loss of driving privileges, lost custody of children, and hiring disqualification based on a prior history of addiction treatment. It is unclear, for example, how many adolescents involved in transient alcohol and other drug experimentation have been misdiagnosed as having a substance use disorder as a result of professional misjudgment or institutional (financial) exploitation of the adolescents' families.

At its extreme, false positives include "iatrogenic artifacts"—diseases made up by professional helpers that rise to the status of diagnostic fads only to later be scientifically discredited, e.g., nymphomania, repressed memory, and multiple personality disorder. In the late 1980s, the newly formulated "disease of co-dependency" generated great professional and cultural interest before coming under attack. Critics of the excessive promotion of co-dependency charged that there was no such disorder—that the diagnostic indicators of co-dependency were so broad as to include nearly everyone and that the concept was being over-extended for the financial gain of therapist specializing in its treatment. Feminists also charged that by defining the problem of "women who love too much" as one of psychopathology, professionals were failing to hold abusive men accountable for their neglectful, demeaning and violent behavior (Kaminer, 1992; Katz & Liu, 1991; Travis, 1992). False positives can inflict harm by attributing pathology where none exists (via consequences of unneeded treatment) or result in misdiagnosis (via consequences of the wrong treatment or the wrong target of intervention).

Harm can also result from false negatives in the assessment process, e.g., failing to identify the presence of existing problems. Several factors contribute to false negatives in the diagnostic process: 1) the over-reliance on client self-report, 2) the failure to adequately involve collaterals in the assessment process, 3) the failure to obtain independent reports that could aid the diagnostic process (e.g., the complete criminal and driving records of those referred for evaluation following an arrest for driving while intoxicated), and 3) the lack of objective laboratory tests to aid the diagnostic process. This risk is particularly

pronounced when clients are referred from coercive institutions and fear the (real and imagined) consequences that could follow a positive diagnosis. The nature of iatrogenic harm from false negatives includes the failure to get treatment by those who need it and the threats these same individuals will pose in the future to themselves, their families and their communities.

Long-term recovery from severe substance use disorders requires resolution of these disorders and the broader problems and circumstances in which they tend to be nested. These collateral problems and conditions can impede recovery, contribute to relapse and compromise the quality of life in long-term recovery. Failing to identify co-occurring medical/psychiatric disorders, historical or developmental trauma or a lack of family and community recovery capital in the post-treatment environment, or other critical issues can elicit potential harm as a consequence of the assessment process.

Harm from Treatment Dosage or Type Harm from a faulty assessment process is often continued through the subsequent placement decisions. Three types of harm can flow from such decisions. The first results in too little treatment—the placement of a client with high problem severity/complexity and low recovery capital in a treatment protocol that lacks sufficient intensity and duration to achieve effective recovery initiation and community-based recovery maintenance. Such inadequate doses are often following by punishment for post-treatment relapse, e.g., incarceration, divorce, lost custody of children. Like inadequate doses of antibiotics, they also often result in the return of the condition in more virulent and difficult-to-treat form. Weak therapeutic alliance and the resulting disengagement of the client, the administrative discharge of non-stabilized clients for alcohol/drug use, and withholding pain medication from people in addiction recovery are other examples of iatrogenic harm from too little treatment.

Too much treatment poses a risk of iatrogenic harm when it exposes a client to overly restrictive levels of care, unnecessary procedures or unneeded lengths of service involvement—all of which may be measured in financial costs, personal/family/work disruption, and the risk of treatment burnout and premature service withdrawal. Too much treatment can also be thought of in terms of doses of a particular service ingredient (whether dosage of a prescribed drug or a prescribed group) that are optimal at one quantity/frequency but create adverse effects at higher quantities/frequencies. An extreme example of this principle would be a methadone overdose death during methadone induction.

The great vision of client-treatment matching was that individual clients could be rigorously assessed and personally matched to particular treatments to produce the greatest possible positive effects. That certain types of clients would excel in one type of treatment but not another would seem evident, but scientific studies have not yet isolated variables to achieves such treatment matching (Project MATCH Research Group, 1997). (We anticipate that such matching possibilities will improve in the future, e.g., through the isolation of genetic factors that predict optimal responses to particular drug/vaccine therapies.) There is evidence to date of potential client-treatment mismatches. Clients with medium to high levels of anger achieve poorer outcomes when involved in therapies with higher confrontation strategies (Karno & Longabaugh, 2005, 2007), and adolescents whose parents have substance-related problems fare poorer in family therapy than in other modalities (Leichtling, Gabriel, Lewis, & Vander Ley, 2006).

Harm from Deviations in Therapeutic & Professional Practice Protocols Therapeutic and professional practice protocol, as reflected in organizational policy and procedure manuals, manual-guided therapies (and adherence monitoring procedures) and organizational codes of ethics serve important client protection functions. Examples of actions that can result in harm to clients when such protocols are not followed include breaches in

confidentiality, medication errors, and injury from therapeutic freelancing. The latter is of particular concern when it involves new, experimental therapies that are not closely monitored through clinical supervision.

Harm from Established Therapeutic Protocols There are cases in which the clients can be injured from standard service protocol. Such injuries include anticipated adverse reactions (e.g., known and common side effects of medication), unanticipated reactions (e.g., idiosyncratic or allergic reactions to medication), and the institutionalization of a treatment ingredient that has the potential to harm the majority of persons receiving it, e.g., problems arising from standard methadone maintenance doses that are set too low of too high. The potential for harm rises with the newness of a procedure, the invasiveness of the procedure and the lack of information on for whom the procedure is contraindicated. Reported deaths during ultra-rapid opiate detoxification and Ibogaine-assisted opiate detoxification typify such potential (Kleber, 2007). Deaths can also occur as a side-effect of treatment, as has been reported during methadone induction, as a lethal side effect of Antabuse-alcohol interactions, and as a result of physical prostration or physical abuses that have occurred within some teen boot camps or wilderness camps.

The greatest magnitude of harm from standard therapeutic protocol accrues from inert (no effect) treatments that prevent clients from accessing alternative treatments that have been proven to generate better long-term recovery outcomes.

Harm from the Service Milieu / Service Relationship Injury to clients in addiction treatment resulting from the service milieu or a particular service relationship encompass such areas as the following:

- Exposure to infectious agents within the service milieu
- Injury or fatality related to seclusion or restraint procedures
- Injury via increased deviance from mixing adolescents with high and low levels of conduct disorder symptoms (Varied findings in the research: see Macgowan & Wagner, 2005 for a review: See Dishion, McCord & Poulin, 1999 and Burleson, Kaminer & Dennis, 2006 for conflicting findings)
- Financial exploitation (For an expose of such exploitation in the troubled teen industry, see Szalavitz, 2006)
- Emotional, social or sexual exploitation of clients by professional helpers (White, 1995)
- Clinical abandonment of clients by professional helpers, e.g., precipitous termination at exhaustion of financial benefits (White & Popovits, 2000)
- Injury from involvement in a therapeutic cult (Janzen, 2001; Temperlin & Temerlin, 1982).

Studies of clinical deterioration during addiction treatment have found such deterioration linked more to shared program characteristics than different clinical approaches or unique client characteristics. Program characteristics linked to clinical deterioration include poor therapeutic alliance, weak bonding of clients to the treatment milieu (e.g. high attrition), weak structure and supervision of clients, low expectations of clients, and high levels of emotional arousal and confrontation (Ilgen & Moos, 2005; Ilgen & Moos, 2006).

Lessons from the Rearview Mirror

There are several important lessons contained in the history of iatrogenesis in addiction treatment. The following are among the most important.

Announcements of great breakthroughs in the treatment of addiction are from a historical perspective notoriously unreliable. Cultivate professional skepticism in response to any claims not backed by replicated studies in the field's leading peer-reviewed journals.

Harmful interventions are often shrouded in claims of scientific breakthroughs, expert opinion and client testimonials during their initial promotion. Beware of any treatment method claiming a high "cure" rate that rests only on "junk science,"[1] professional endorsements linked to personal or institutional profit, and selected client testimonials.

Harmful effects of addiction treatment are often written off as symptoms of the client's addiction pathology or as products of medical psychiatric co-morbidities. If we attribute positive change in clients to the potency of key treatment ingredients, we must also consider that negative change in some clients may flow from these same potent forces.

Members of historically disempowered groups are particularly vulnerable to iatrogenic injury, e.g., women, children, elderly, ethnic minorities, prisoners, and persons experiencing stigmatized conditions, e.g., mental illness, addiction. Iatrogenic injury most often comes to light when it is inflicted on a person/family of power and influence as occurred in the exposure of harm from Carbon Dioxide Therapy. Extra efforts must be made to protect the historically disempowered from such injury.

Professionals who first challenge harmful interventions are at risk of being labeled heretics and being scapegoated and extruded from their organizations and the larger field. If you choose to challenge what you perceive to be harmful policies or service practices, seek consultation from professional mentors and professional associations to support you through this process.

Adverse events that are covered up tend to be recapitulated in the future in more severe forms. Treatment procedures with iatrogenic effects do not spontaneously dissipate. Someone must stop them. Those who have spoken out to stop harmful practices in addiction treatment are as much deserving of pioneer status as those who introduced beneficial practices.

"First Do No Harm"

In closing this essay, we would like to suggest prescriptions that we hope will stir discussion about how addiction professionals can prevent and respond to iatrogenic injury.

1. Use your preparatory training and continued education to heighten and sustain your awareness of the potential sources of iatrogenic injury.

2. Recognize the variability of response to all treatments--optimal response, partial response, non-response or adverse response—and remain watchful for the latter.

3. Remain particularly alert to the potential for iatrogenic injury to members of historically disempowered service populations.

4. Commit yourself to evidence-based practices & fully participate in fidelity monitoring protocol related to such practices.

5. Utilize clinical supervision to prevent and intervene quickly in response to clinical deterioration and report/review/document all incidents of clinical deterioration following initiation of treatment procedures.

6. Solicit formal approval from your clinical supervisor before using any experimental service procedures (those outside of standard clinical protocol).

7. Practice within, and only within, the boundaries of your education, training and

[1] By "junk science" we mean the use of faulty scientific data or analysis to promote particular ideological or financial interests, e.g., follow-up studies that rely only on telephone follow-ups without family or drug testing corroboration and skewed samples—only reporting on treatment "graduates" or those with a high (6-12 month) service dose.

experience and within professional/organizational codes of ethics.

8. Rigorously utilize mechanisms of client protection, e.g., established service protocol, informed consent, confidentiality guidelines, infection control and other safety procedures.

9. Solicit ongoing feedback from clients, family members and referral sources on their observations of effects of service procedures; encourage clients and families to use mechanisms for complaint and redress, e.g., grievance procedures.

10. Recognize your professional and organizational obligation to speak out about possible iatrogenic injury when you observe it.

11. Consider whistleblowing when other venues of redress have been exhausted; Remember, you may be held professionally, ethically and even legally liable for failing to report an adverse event caused by your own action or the actions of others.

12. Conduct research involving clients only with the approval by an Institutional Review Board (IRB).

13. Make personal/professional amends where iatrogenic injuries may have occurred.

Summary and Closing

This essay has defined iatrogenic injury in addiction treatment via its history, current prevalence, and forms, and it has offered suggestions on how such injury can be prevented and corrected. It is easy to look back with self-righteous indignation at the professional insults that have been inflicted upon those addicted to alcohol and other drugs, but one wonders how our own era will be judged in the future. Who within our own period will future historians call the healers and who will they castigate as the hustlers and charlatans? What harm done in the name of good exists today in the field of addiction treatment? The history we have reviewed calls for clinical humility and a continual pledge to follow the first of all ethical mandates: *First do no harm.*

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Skipper, G.E., DuPont, R.L. & White, W.L. (2008). Testing for recent alcohol use. *Perspectives: The Journal of the American Probation and Parole Association*, 32(3), 38-45. Posted at **www.williamwhitepapers.com**

Testing for Recent Alcohol Use

Abstract

Drug testing is a powerful tool in the prevention, early intervention, treatment, and the management of drug-related problems. Over the past 25 years, drug testing has dramatically increased in business and industry, the U.S. military, secondary schools, professional sports, addiction treatment programs, the criminal and juvenile justice systems, and the child protection system. The Achilles' heel to the current system of drug testing has been that routine testing procedures until recently excluded the most widely used intoxicant in the United States. Monitoring individuals for recent alcohol use is hampered by the rapid metabolism of alcohol. Until recently, this has limited alcohol testing to a few hours after drinking stops. Several new developments are making it easier to test for alcohol use in the 3-5 days preceding the test by identifying the presence of alcohol metabolites (the by-products of the body's processing of alcohol). This is especially important in monitoring alcohol use in settings in which no alcohol use is permitted, e.g., alcoholism and drug abuse treatment, professional assistance programs, abstinence as a condition of probation or parole, or child custody, and for people under the legal drinking age. This article describes these new testing procedures and suggests ways they can be successfully integrated into a comprehensive probation- and parole-based alcohol and drug testing program. Because these tests for alcohol use are new, the practice guidelines are evolving rapidly. We describe the current best practices in the new testing



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Citation: White, W. (2008) Recovery and public service. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*, Winter, p. 5. Posted at **www.williamwhitepapers.com**

Recovery and Public Service

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Critics of recovery mutual aid societies have argued that such societies foster cult-like isolation and thwart broader community participation. The historical record and recent scientific studies challenge such criticisms.

Recovering individuals and their families have played important roles in local and national alcohol policy debates. Recovery activists such as John Gough, John Hawkins, Dr. Henry Reynolds and Francis Murphy played leadership roles in the larger temperance movement of the nineteenth century. In the 1890s, members of the Keeley Leagues demonstrated in support of legislation to provide state funding for treatment of indigent alcoholics. That tradition of advocacy continued through the work of Marty Mann and the National Council on Alcoholism. One could build a convincing historical case that there would be no modern system of addiction treatment without the legions of recovering people and their families who spent decades advocating for the development of such a system of care. AA co-founder Bill Wilson testifying before a 1969 congressional committee in support of the landmark legislation that birthed the treatment system as we know it today constitutes a landmark of such public service.

But what of broader levels of community involvement? In 2003, Linda Farris Kurtz and Michael Fisher published a study in Contemporary Drug Problems on the level of participation in community life by AA and NA members. They found a high level of community service by AA and NA members in long-term recovery. AA and NA members reported that their volunteer involvement in helping agencies, schools, civic groups, professional associations, political parties, advocacy groups, cultural groups and religious organizations was a way of giving back to their communities the gifts that had come to them through their recoveries.

Personal recovery is a catalyst for community participation and public service. Those on the front lines of the New Recovery Advocacy Movement in the United States are writing new chapters within that tradition.



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2008) Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse*, 43, 1-14. Posted at **www.williamwhitepapers.com**

Recovery: Old Wine, Flavor of the Month or New Organizing Paradigm?

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Abstract

Recovery is emerging as an influential but ill-defined organizing concept for addiction treatment[1] and the larger field of behavioral health care. The reification of the concept of recovery is discounted by some as nothing new ("We're already recovery oriented."), an ephemeral fad lacking substance and import ("This is old wine in a new wineskin."), or as hopelessly impractical ("Nobody will pay for it."). This essay uses historical analysis and treatment system performance data to argue that recovery is a revolutionary concept. Policymakers who are embracing this concept via the vision of a recovery-oriented systems of care are, in spite of innumerable obstacles, radically altering the present design of addiction treatment.

El restablecimiento surge como concepto de organización influyente pero mal definido para el tratamiento de inclinación y campo mayor de salud comportamental. El reification del concepto del restablecimiento se espera por algunos como nada de nuevo ("somos ya restablecimiento orientado"), una manía transitoria careciendo de sustancia e importación ("es viejo vino en un nuevo wineskin."), o como desesperadamente impracticable ("nadie lo pagará lo."). Esta prueba emplea datos históricos de ejecución de análisis y sistema de tratamiento

[1] Treatment can be briefly and usefully defined as a planned, goal directed change process, which is *bounded* (culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help based (AA,NA, etc.) and self-help ("natural recovery") models. There are no unique models or techniques used with substance users- of whatever types- which aren't also used with non-substance users. In the West, with the relatively new ideology of "harm reduction" and the even newer Quality of Life (QOL) treatment-driven model there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence driven models. Non-clinical support and help is part of a broad range of mutual aid process which is not unique to the substance use(r) intervention arena. Editor's note.

para alegar debido a que el restablecimiento es un concepto revolucionario. Los decisores que abarcan este concepto por medio de la visión de los sistemas restablecimiento- orientados de cuidado, a pesar de obstáculos innumerables, cambian radicalmente la concepción actual del tratamiento de inclinación.

Le rétablissement émerge comme concept d'organisation influent mais mal défini pour le traitement de penchant et champ plus grand de santé comportementale. Le reification du concept du rétablissement est escompté par certains en tant que rien de neuf ("nous sommes déjà rétablissement orienté"), une manie éphémère manquant de la substance et importation ("c'est vieux vin dans un nouveau wineskin."), ou comme désespérément impraticable ("personne ne payera lui."). Cet essai emploie des données historiques d'exécution d'analyse et de système de traitement pour arguer du fait que le rétablissement est un concept révolutionnaire. Les décisionnaires qui embrassent ce concept par l'intermédiaire de la vision de l'les systèmes rétablissement-orientés du soin, malgré des obstacles innombrables, changent radicalement la conception actuelle du traitement de penchant.

KEY WORDS for Indexing: recovery, recovery capital, sustained recovery, recovery mutual aid, recovery management, chronic disease model

Introduction

In the alcohol and other drug use-related problems arena, *recovery* has moved from a culturally hidden and highly personal lived experience to a conceptual fulcrum of change for addiction-related social and political policies and the clinical design of addiction treatment (White, 2005a). The recovery mantra seems to be everywhere. Addiction recovery mutual aid groups have grown internationally and now span religious, spiritual, and secular frameworks of recovery (Humphreys, 2004; White, 2004a). Recovering people and their families have joined with visionary professionals to rebirth grassroots addiction recovery advocacy organizations and link these local organizations into an increasingly visible national movement (White, 2006a; www.facesandvoicesofrecovery.org). Recovery-focused public education campaigns (e.g., Recovery Month, www.recoveryiseverywhere.com) and recovery celebration events (e.g., marches and festivals) are rapidly increasing. This advocacy movement has spawned a related movement to expand non-clinical recovery support roles (e.g., outreach workers, recovery coaches, recovery support specialists) (White, 2006b) and recovery support service institutions (e.g., recovery community organizations, recovery homes, recovery schools, recovery-based industries, recovery churches) (Jason, Davis, Ferrari, & Bishop, 2001; White & Finch, 2006).

In the professional treatment arena, there have been sustained calls to reconnect treatment to the larger and more enduring process of addiction recovery (Morgan, 1995; Else, 1999; White, 2004b) by shifting addiction treatment from a strictly acute care model of intervention to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002; Dennis & Scott, in press). Calls have also been made to use recovery as a conceptual bridge in the integration of the addiction treatment and mental health fields (White, Boyle, & Loveland, 2004; Davidson & White, in press; Anthony, Gagne, & White, in press).

At the policy level, there is clear evidence of recovery-focused shifts in national behavioral health care policy (DHHS, 2003; Institute of Medicine, 2006). These shifts have moved beyond a new rhetoric to serious attempts to elevate recovery and the role of recovering people and their families within federally-sponsored

activities, e.g., the Center for Substance Abuse Treatment's (CSAT) Recovery Summit and other recovery-themed conferences as well as new service initiatives such as CSAT's Recovery Community Support Program (RCSP)[2] and Access to Recovery (ATR) program[3]. Also spreading are state and urban initiatives to transform addiction treatment into a "recovery-oriented system of care" led by the examples of the Connecticut Department of Mental Health and Addiction Services and the Philadelphia Department of Behavioral Health. Increased interest in recovery is also evident in the growing number and quality of scientific studies on the pathways and processes of long-term recovery from addiction as evidenced by special issues on recovery by the field's peer-reviewed scientific journals, i.e., *Substance Use and Misuse*, *Journal of Substance Abuse Treatment*, and *Alcoholism Treatment Quarterly*.

All of this raises questions of what this recovery focus is all about and whether it constitutes something of great value that is being newly discovered or rediscovered, or whether it is a passing fad that will exert little influence on the future of addiction treatment. The purpose of this essay is to explore such questions by briefly reviewing the history of recovery as an organizing concept.

Recovery Mutual Aid: A Historical Synopsis

American communities of recovery have a long and rich history. American recovery mutual aid societies date from eighteenth and nineteenth century abstinence-based Native American religious and cultural revitalization movements: recovery circles of the Delaware Prophets, Handsome Lake Movements, Shawnee and Kickapoo Prophet movements, the Indian Shaker Church, and early Sacred Peyote Societies that were later organized as the Native American Church (Coyhis & White, 2006). These societies provided culturally-mediated pathways of recovery from alcohol consumption-related problems that grew in the wake of the physical and cultural assault on Native American tribes.[4]**.** A dramatic rise in overall per-capita American alcohol consumption between 1780-1830 (from 2 ½ gallons annual per capita to more than 5 gallons annual per capita—nearly 3 time current American alcohol consumption) (Rorabaugh, 1979) triggered the American temperance movement and a long series of recovery support structures: the Washingtonians (1840s), the Fraternal

[2] The Recovery Community Support Program is a grant program initiated by the Center for Substance Abuse Treatment in 1998. Its early focus was on funding more than 30 local community organizations across the United States to mobilize communities of recovery, advocate pro-recovery social policies, run anti-stigma campaigns, and offer needed recovery support services. In 2002, the program changed to the Recovery Community Services Program with a focus on the development of peer-based recovery support services.

[3] The Access to Recovery (ATR) Program is the product of a 2003 Presidential initiative that is now administered by the Center for Substance Abuse Treatment. The ATR program provided vouchers to people seeking addiction treatment and/or recovery support services so that they could choose those services that best suited their needs and circumstances. More than $100 million a year in ATR funds are channeled through state and tribal organizations.

[4] The role of historical trauma and colonization in the rise and maintenance of Native American alcohol consumption problems has been explored in considerable depth by Coyhis & White (2006), Brave Heart, & DeBruyn, 1998; Brave Heart, 2003; and Morgan, 1983. These sources document the role of alcohol in the economic, political and sexual exploitation of Native Americans; the creation of "firewater myths" as an instrument of colonization; and the Native American religious and cultural revitalization movements through which Native Americans resisted and responded to alcohol consumption problems. The latter movements include the Prophet Movement among the Delaware, Shawnee and Kickapoo; the Handsome Lake Movement, the Native American Temperance Movement, the Indian Shaker Church and the early Peyote Societies that evolved into the Native American Church.

Temperance Societies (1850-1900), the Dashaway Association (1859), the Royal and Blue Ribbon Reform Clubs (1870s), and such religiously oriented recovery groups as the Drunkard's Club (1870), the Jacoby Club (1910), and the United Order of Ex-Boozers (1914) (White, 2001; Dubiel, 2004).

Today's Twelve Step recovery programs date to the 1935 founding of Alcoholics Anonymous. The history of A.A. has been marked by a progressive growth in overall membership and the number of registered groups, a diversification of A.A. member characteristics (by age, gender, ethnicity, sexual orientation, occupational background, and co-occurring problems), and a growing diversity of styles of recovery within A.A. A.A.'s Twelve Steps have been adapted to create anonymous recovery programs for those with other drug choices: narcotics (1948, 1953), marijuana (1968 & 1989), pills (1975 & 1998), cocaine (1982), nicotine (1985), benzodiazepines (1989), methamphetamine (no founding date available) and heroin (2004). Twelve step addiction recovery groups have also been created that transcend drug choice categories such as Chemically Dependent Anonymous (1980) and Recoveries Anonymous (1983) (Kurtz E., Kurtz L., & White, in press), and applied to a multitude of other human problems, e.g., Gamblers Anonymous, Overeaters Anonymous, Debtors Anonymous.

Modern alternatives to Twelve Step addiction recovery programs began in the mid-1970's and grew rapidly throughout the 1980s and 1990s. Such alternatives include:

- gender-specific recovery groups (Women for Sobriety, 1975; 16 Step Discovery & Empowerment groups, 1991; Mothers on Methadone, 2005),
- secular alternatives to Twelve Step Programs (Secular Organization for Sobriety/Save Our Selves, 1985; Rational Recovery, 1986; Men for Sobriety, 1988; LifeRing Secular Recovery, 1999; SMART Recovery®, 1999),
- explicitly religious alternatives to Twelve Step Programs (Alcoholics for Christ, 1976; Celebrate Recovery, 1990; One Addict—One Church, 1994; Millati Islami), and
- moderation-based support groups (Methods of Moderation and Management, 1983; Moderation Management, 1994) (Kurtz E., Kurtz, L., & White, W., in press).

It can be seen from this review that organized frameworks of recovery predate the birth, and have existed independent of, addiction treatment institutions, the latter marked by the opening of the first inebriate home (1857), inebriate asylum (1864), and private addiction cure institute (1879) (White, 1998). For more than 250 years, these recovery societies have relied on recovery support strategies that include such actions as public confession; public commitment to abstinence; sober fellowship through regular and sustained participation in experience-sharing meetings and related social activities; the discovery of previously hidden resources within and/or beyond the self; a reconstruction of personal values, identity and interpersonal relationships; and service to others as a mechanism of self-healing (White, 1998; Kurtz, Kurtz, & White, in press).

Throughout this history, debate has continued as to whether the process of resolving alcohol and other drug use- related problems is one of reform, redemption, recovery, reconstruction, maturation, or transformation. Since contentions that those in the Washingtonian movement should be called "reforming" rather than "reformed" (Harrison, 1860), debate has continued over whether this resolution is best thought of as a point in time event (e.g., a decision, an act such as signing a temperance pledge) or an ongoing process. Recovery has been the central organizing concept for recovery support groups, but that has not always been the case for addiction treatment institutions treating a broad range of substance users who represented a heterogeneous population of people.

Recovery Mutual Aid and Professional Treatment

The relationship between addiction treatment institutions and recovery mutual aid organizations is a complex and ambivalent one. The therapeutic branch of the American temperance movement called for the rescue of inebriates through outreach from temperance societies and the creation of specialized institutions for the care of the inebriate (Woodward, 1836). A network of inebriate homes, inebriate asylums and private addiction cure institutes rose on the American landscape in the mid-nineteenth century before collapsing in the opening decades of the twentieth century (White, 1998). These early institutions saw themselves providing treatment that would "*cure*" the "*disease of inebriety,*" and gave little thought to the post-institutionalization adjustment process. When these early institutions closed, decades of public education and advocacy (the "*modern alcoholism movement*" of the 1940s through the 1960s) were required to rebirth today's national network of addiction treatment programs.

Throughout this history, there has been a complex and mutually ambivalent relationship between professionally-directed treatment institutions and peer-based recovery mutual aid societies. Addiction treatment programs have been spawned by recovery mutual aid societies. The Home for the Fallen (1857) was founded by the Washingtonians and later re-opened as the Washingtonian Home, and the Dashaways established the San Francisco Home for the Care of the Inebriate (1859) (White, 1998). Once established, these institutions tended to become medicalized and professionalized and progressively detached from their founding bodies.

There were also institution-based recovery mutual aid groups formed by the patients being treated at these institutions. Such groups, what today would be called "consumer councils" or "alumni associations," included the Ollapod Club (1868) founded at the New York State Inebriate Asylum, the Godwin Association (1872) founded at the Franklin Reformatory Home for Inebriates in Philadelphia (White, 2001), the Keeley League (1891) founded within the Keeley Institute (Barclay, 1964), and the Jacoby Club (1910), which was associated with the Emmanuel Clinic in Boston (Dubiel, 2004).

The complex relationship between addiction treatment and recovery mutual aid groups is most evident in the history of Alcoholics Anonymous (AA) and modern addiction treatment. Several of AA's character-shaping events occurred in the context of treatment: psychiatrist Carl Jung's refusal to readmit Roland Hazard as a patient and Bill Wilson's climactic spiritual experience at Charles Towns Hospital. AA co-founder Bill Wilson was offered a paid position as a lay alcoholism psychotherapist (which he declined), and AA had plans for founding alcoholism treatment hospitals (which it later abandoned) (White & Kurtz, in press). The potential difficulties of mixing mutual aid with professional treatment or policy advocacy led to AA's policies of singleness of purpose and non-affiliation with outside enterprises and controversies. Given earlier histories of addiction treatment institutions colonizing mutual aid societies for their own purposes (e.g., the collapse of the Keeley League following their takeover by the Keeley Institute founder), AA's position seems a historically wise one.

There is a delicate and difficult to sustain balance in the relationship between addiction treatment institutions and recovery mutual aid societies. If treatment and recovery support institutions become too close or are merged, there is a tendency for one of these critical functions to be lost. Either treatment ceases being treatment and becomes that which is available for free outside of professional service settings, or recovery support becomes professionalized and ceases being based on mutual vulnerability and shared recovery experience. If treatment and recovery support institutions become too distant from one another, mutual aid members lose their access to needed treatment and treatment graduates lack connection to ongoing recovery supports. Historically, both

recovery mutual aid and professional treatment have value, but destroy themselves when they lose their identity and boundary integrity (White & Kurtz, in press). When mutual aid members provide "treatment" they exceed the boundaries of their education, training and experience and threaten harm and injury to those they serve. When treatment becomes nothing but mutual aid, it offers a paid professional service what its consumers can receive in the larger community without cost. Treatment relationships are externally-regulated (by government and voluntary licensing and accreditation standards governing treatment institutions, professionally-grounded (by ethical codes of the professions represented in the service team), fiduciary (one party assuming ethical and legal obligation for the care of another), commercialized (someone is paying the helping institution and helping provider) and usually time-limited. Recovery mutual aid relationships are internally regulated (governed by organizational values of group conscience), reciprocal, non-commercialized and potentially enduring.

Through the processes of professionalization (the evolution of addiction counseling from a folk art provided by indigenous recovering people to a profession governed by educational, licensure and accreditation standards promulgated by external bodies) and industrialization (the evolution of addiction treatment institutions from community-based service organizations to highly regulated businesses) modern addiction treatment as an activity and a field of professional endeavor became disconnected from the larger process of recovery and from indigenous communities of recovery. That disconnection is evident in changes in the addiction field perceived by the author in his travels (100+ days per year) as a trainer and consultant with addiction treatment programs over the past 35 years (See White, 1998 for discussions of the evolution of modern addiction treatment). Those changes include:

- declining percentage of recovering people working in the field in administrative and clinical positions,
- decreased recovery representation on treatment institution boards,
- abandonment of service advisory boards made up mostly of recovering persons,
- diminished expectation that treatment professionals would attend local open meetings of mutual aid societies,
- loss of recovery-based volunteer programs,
- decline of alumni programs,
- abandonment of formal meetings between addiction treatment institutions and the formal service structure (e.g., hospitals and institution committees) of mutual aid groups, and the
- shift from assertive linkage procedures (to a particular person or meeting or taking a person to one or more meetings) to passive linkage procedures (verbal encouragement to attend recovery support meetings) between addiction treatment and recovery mutual aid societies.

Several long-time observers of addiction treatment have noted the deterioration of the connective tissue linking the worlds of addiction treatment and recovery mutual aid and have called for renewing these relationships (Zweben, 1986; Morgan, 1995; White, 1996; Else, 1999). Considerable effort is currently underway to re-instill assertive linkage procedures between addiction treatment programs and American communities of recovery (White & Kurtz, 2006).

Towards a Recovery Paradigm

The intensification of interest in recovery marks a shift from pathology and intervention paradigms to a solution-focused paradigm. The knowledge base of the "addictions field" or "treatment field" has been drawn primarily from a study of

pathology. The field's knowledge of toxico-pharmacology, the neurobiology of psychoactive drugs, the etiology and patterns of alcohol and other drug (AOD) use -related problems, and professional interventions into AOD use-related problems is immense in terms of scientific data and publicly accessible information. There are admittedly significant problems in the gap between knowledge drawn from research within these pathology and intervention paradigms and front line clinical practice—a problem further complicated by the highly politicized environment surrounded AOD use-related problems. But what is being suggested here is something quite different: that the knowledge base from which knowledge is being drawn to influence clinical practice lacks a central sphere of investigation. As a field, we have all manner of organizations and journals whose names reflect our focus on the problem, but not a single federal or state agency and not a single journal whose name declares its singular focus on recovery. Would a National Institute on Addiction Recovery operate differently than a National Institute on Drug Abuse? Would a *Journal of Addiction Recovery* address different questions than existing publications such as the *Journal of Psychoactive Drugs* or the *Journal of Substance Abuse Treatment*? The field has yet to shift to a paradigm centered on the solutions to AOD use-related problems for individuals, families, and communities.

Prevalence data on recovery is miniscule compared to the mass of data on drug use trends and drug use-related casualties (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Little is known about the pathways, styles, and stages of long-term problem resolution and how these vary across demographic and clinical subpopulations (White, 2004a). There is considerable literature on how various posited risk factors[5] can increase vulnerability for addiction and compromise recovery outcomes, but little research on how different types of recovery capital can offset such risk factors and mediate recovery among even those with the most severe problems (Laudet & White, in press). A consistent theme of the Center for Substance Abuse Treatment's recent Recovery Summit was the need for a recovery research agenda that would illuminate successful long-term solutions to AOD problems. As we will see shortly, the evolution to a recovery paradigm has significant clinical implications for the design and evaluation of addiction treatment, but there is a dearth of data to guide that evolution.

Addiction treatment as historically designed has been focused on brief biopsychosocial stabilization, not sustainable long-term recovery. This acute care (emergency room) model is distinguished by several key characteristics:
1) problem intervention is marked by an encapsulated and prescribed series of professional activities (screen, assess, diagnose, admit, treat, discharge, terminate the service relationship),
2) a professional expert directs the process,
3) services transpire over a short (and historically ever-shorter) period of time, and
4) the individual/family/community is given an impression at discharge ("graduation") that full recovery is now attained and self-sustainable without ongoing professional assistance.

The acute care model of addiction treatment does generate sustainable abstinence through typically short (1-3 year) follow-up periods for a minority of individuals (one-

[5] This concept, (and its 'first-cousin, "protective factors). often noted in the literature, is all-too-often used without adequately understanding and considering its dimensions (linear, non-linear), its "demands", the critical necessary conditions which are necessary for it to operate (begin, continue, become anchored and integrate, change as de facto realities change, cease, etc.) or not to and whether its underpinnings are theory-driven, empirically-based, individual and/or systemic stake holder- bound, based upon "principles of faith" or what. What is necessary – endogenously as well as exogenously for a "risk" process to operate? This is necessary to clarify if the term is not to remain as yet another shibboleth in a field of many stereotypes. If we don't currently know, in a generalizable sense- it behooves us to state this. Editor's note.

forth to one-third) thus treated and substantial reductions in the frequency of drug use among others (Miller, Walters & Bennett, 2001), but slogans like "Treatment Works" mask fundamental problems with this model.

Among the major problems of the acute care model of addiction treatment are its failure to acknowledge people who resolve alcohol and other drug use problems without professional intervention (and distinguish those who need and do not need professional intervention), low voluntary attraction (resulting in typically late stage problem intervention), obstacles to access (e.g., waiting lists), attrition (more than 50% of persons admitted fail to successfully complete), inadequate service quality (Magura, 2000), inadequate service dose (less than that prescribed in NIDA's *Principles of Addiction Treatment*), exposure to treatment methods proven to have minimal or even harmful effects[6] (see White, 1998 & Moos, 2005 for historical and contemporary reviews on the latter), post-treatment relapse (more than 50% of those treated and followed at one to five year intervals following discharge), and treatment readmission (See White, 2005c for a review). The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admissions, including 22% with 3-4 prior admissions and19% with 5 or more prior admissions (SAMHSA-OAS, 2005). Between 25-35% of clients discharged from addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within 2-5 years (Simpson, Joe, & Broome, 2002).

It is quite clear that a growing number of people are entering addiction treatment in the United States whose problem severity, complexity and chronicity, and low recovery capital are not being fundamentally altered via this acute care model of intervention. The American treatment system has repeatedly and erroneously interpreted brief, professionally facilitated biopsychosocial stabilization as sustainable recovery. Such episodes are as likely to be a milestone in one's addiction career as a milestone of entry into the recovery process, as the public parade of celebrities heading back to boutique rehabs regularly demonstrates. The continued misrepresentation of the likely outcomes of the acute care model of professionally-directed addiction treatment has potentially ominous consequences. Such misrepresentation to service consumers and their families, referral sources, policy makers, and the public risks a backlash that could revoke addiction treatment's probationary status as a cultural institution. The acute care model of addiction treatment is culturally and clinically unsustainable.

The design of addiction treatment—particularly for those with the most severe AOD problems--should be radically altered if the goal and focus of treatment shifted from brief stabilization to sustainable recovery. If addiction treatment was really designed to support sustainable recovery, it would require abandonment of several mainstream clinical practices, e.g., conveying the impression that all clients should achieve permanent abstinence following brief treatment (and punishing them when they fail to achieve this goal), administratively discharging clients for confirming their diagnosis (see White, Scott, Dennis, & Boyle, 2005), and terminating the service relationship following brief contact—a practice that would be unthinkable in the treatment of any other chronic health care problem. Concepts such as graduation, discharge, and aftercare (as currently conceptualized) would be similarly abandoned for those with severe and persistent AOD problems.

For treatment to foster sustainable recovery, the following strategies would be required:

- thresholds of access and engagement would be lowered,

7 Common treatment methods with little or no evidence of their effectiveness include lectures, educational films, general alcoholism counseling and milieu therapy (Wilbourne & Miller, 2002); an example of potentially harmful interventions include confrontational counseling technigues (See Whitr & Miller, 2007 for a review.)

- therapeutic alliances would be strengthened and sustained and should focus as well, not only on the substance user patient but also on the change agent, which is rarely if ever done,
- global, continuing, and strengths-based assessment would be the norm,
- professionally-directed treatment plans would be replaced by, or rapidly transition to, client-generated, partnership-drive recovery plans (See Borkman, 1997),
- peer-based recovery support service roles would be integrated into the multidisciplinary treatment team,
- assertive linkage to, and monitoring of the relationship with, communities of recovery would be a routine practice,
- considerable attention would be placed on the recovery environment of each client with new roles devoted to enhancing each client's external recovery capital,
- treatment programs would form alliances with culturally indigenous recovery support institutions (e.g., churches, cultural revitalization movements), and
- sustained (up to five years) post-treatment recovery checkups (monitoring, support and early re-intervention) would be the norm in addiction treatment (White, 2005b).

Such strategies would require a sustained commitment for recovery focused training and technical assistance for addiction professionals and policy makers, and may require nothing short of major system transformation efforts (Kirk, 2007; Evans, 2007).

The earliest steps in this recovery-focused revolution in clinical policies and practices are already underway at national, state, and local levels (Clark, 2007; Kirk, 2007; Evans, 2007). The future of addiction treatment as a cultural institution hinges on the outcome of these system transformation efforts. Such efforts have been aided by evidence on the chronicity of certain patterns of addiction (McLellan et al., 2000), evidence on the fragility of post-treatment recovery (Scott, Foss, & Dennis, 2005), evidence that sobriety is not fully stabilized until 4-5 years into the recovery process (Jin, Rourke, Patterson, Taylor, & Grant, 1998; Dennis, Foss, & Scott, under review), and evidence that sustained post-treatment monitoring and support can significantly elevate long-term recovery outcomes (Dennis, Scott, & Funk, 2003; McKay, 2005). Post-treatment recovery check-ups have been shown to reduce time to treatment re-admission, increase the dose of treatment following re-admission and increase the prospects of transitioning to stable recovery (Dennis, Scott, & Funk, 2003; Scott, Dennis & Foss, 2005). It has been further suggested that this revolution in thinking and practice may offer special advantages to communities of color and other historically disempowered communities (White & Sanders, in press).

System Transformation Obstacles

The recovery oriented transformation of addiction treatment faces significant obstacles and pitfalls, including major weaknesses in the infrastructure of addiction treatment that may require sustained monitoring and support parallel to that recommended above for individual clients leaving addiction treatment (McLellan, Carise, & Kleber, 2003). Implementation obstacles include conceptual fuzziness of recovery[7] and its related concepts (Betty Ford Institute Consensus Panel, in press; White, in press), funding streams and regulatory requirements designed

[7] Examples of such fuzziness include questions of whether recovery includes an altered relationship with all psychoactive substances—including tobacco, whether the recovery concept embraces problem resolution strategies other than abstinence, whether recovery encompasses medication assistance (e.g., methadone, naltrexone), whether recovery requires more than a resolution of alcohol and other drug use problems, and whether recovery is an all or none concept or whether it is something that could be achieved partially. See White, in press, for a detailed discussion of such questions.

exclusively to support service elements *within* the acute care model, service provider defensiveness, resistance to changes in clinical policies and practices, and lack of scientific research on key recovery-related questions. Some of the most successful strategies of addressing these obstacles include building a strong collation of policy makers, treatment providers and recovery advocacy organizations; honoring what people have done in the past; rigorously evaluating current service practices; generating a shared vision, core values and a planning and implementation process for systems transformation; garnering additional funds to enhance service redesign and new initiatives; providing sustained training to all system stakeholders; and developing a formal communication strategy related to systems transformation that constantly links discrete initiatives to the larger transformation vision and process (Kirk, 2007; Evans, 2007).

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Institutions to Contact for Further Information

Faces and Voices of Recovery (www.facesandvoicesofrecovery.org)
Behavioral Health Recovery Management project (www.bhrm.org)
The Great Lakes Addiction Technology Transfer Center (www.glattc.org)
The Northeast Addiction Technology Transfer Center (www.neattc.org)
The Network for the Improvement of Addiction Treatment (www.niatx.net)
The Connecticut Department of Mental Health and Addiction Services (http://www.ct.gov/DMHAS)
The Philadelphia Department of Behavioral Health (http://www.phila.gov/dbhmrs/

Glossary

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) use-related problems mobilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by these problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, in press).

Recovery capital is the total of internal and external assets that can be drawn upon to initiate and sustain the resolution of alcohol and other drug problems (Granfield & Cloud, 1999).

Recovery check-up is a systematic way to monitor post-treatment progress, provide stage-appropriate recovery education, provide linkage to needed community resources, and to provide, when needed, early re-intervention.

Recovery coach is a recovery-informed person that offers non-clinical recovery support services to persons seeking to initiate and sustain long-term recovery from severe alcohol and other drug use problems.

Recovery management is the stewardship of personal, family, professional and community resources to achieve the long-term resolution of severe alcohol and other drug *use-related* problems (White, Boyle, & Loveland, 2002).

Recovery paradigm is the use of knowledge derived from the experience of recovering people and recovery-focused research to design addiction treatment and long-term recovery support services.

Sustainable long-term recovery is the stable resolution of alcohol and other drug use problems in tandem with improvements in emotional and relational health for more than five years.

Solution-focused paradigms are organizing models that place emphasis on building personal, family and recovery assets rather than on the diagnosis of personal, family and community pathologies.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2008). Phoenix House Consultation Questions & Responses from Bill White. Posted at **www.williamwhitepapers.com**

Phoenix House Consultation Questions & Responses

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1. Besides a recovery support group prior to admission for engagement what other ways can treatment providers engage clients earlier?

I think the most important of these include:

- Assertive outreach programs in hospitals, jails, shelters, needle exchanges—including street outreach conducted by teams of recovering volunteers (some of these are being conducted by consumer councils and alumni associations.
- Assertive waiting list management via assignment of recovery coach to engage, encourage, start treatment activities prior to formal admission, resolve obstacles to admission, resolve ambivalence about admission, etc.
- Assignment of "strength" (a senior client) to each client at point of intake to serve as recovery coach, e.g., coaches can engage and orient client prior to staff assessment and intake; senior clients benefit via "helper principle."
- Using senior staff to induct/indoctrinate new clients.
- "Institutional outreach" (regularly checking in with people) to then sustain engagement and retention

Resource: See chapter on engagement in: White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services; DeLeon, G., Hawke, J., Jainchill, N., & Melnick, G. (2000). Therapeutic communities: Enhancing retention in treatment using "Senior Professor" staff. *Journal of Substance Abuse Treatment*, *19*, 375-382.

2. Have you heard of SMART recovery groups and if so what do you think of the utilization of these recovery groups in conjunction with NA and AA support groups?

Yes, I serve on the scientific advisory board of SMART Recovery and have also collaborated with Secular Organization for Sobriety, LifeRing Secular Recovery and other secular recovery support groups.

Response to all recovery support groups—like all treatment approaches—vary from optimal response, partial response, no response, and adverse response. The trick becomes one of matching the person to a particular community of recovery. The secular recovery support group memberships would indicate their viability for individuals marked by higher levels of education and individuals low in spiritual or religious orientation. More and more programs are moving toward a "philosophy of choice" related to long-term pathways of recovery. Offering choice is limited by the lack of alternatives to 12 step groups in many communities, but dispersion of these alternatives is increasing and online recovery support meetings are growing very rapidly.

Resource: White, W. and Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, 6(4), 58-61; Horvath, A. (1999-2000). SMART Recovery. *International Journal of Self Help and Self Care*, *1*(2), 163-169; White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor,* 9(1), 38-43.

3. Where can treatment providers get self guided recovery management materials?

These are just beginning to be developed. The place that is doing it most systematically is the Philadelphia Department of Behavioral Health via their Tools for Transformation. Recovery advocacy organizations are also beginning to develop such materials, e.g., PRO-ACT in PA and CCAR in CT.

I have also prepared some self-assessment recovery planning tools as part of a larger "toolkit" that I will send to Jennifer and David for distribution.

Resource: For Tools of Transformation info, see Ellen Faynberg at Ellen.Faynberg@phila.gov or 215-685-5463; For materials from PRO-ACT and CCAR, contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771 at PRO-ACT or Phil Valentine at phillip@ccar.us at CCAR.

4. Engaging and maintaining voluntary consumer councils, advisory boards, and alumni associations, which are vital sources of support, is difficult for obvious reasons. What successful methods have you seen?

The most dynamic consumer council I have seem is the NET Consumer Council in Philadelphia. Here is a profile of their Council.

Program Profile: NET Consumer Council (NorthEast Treatment Centers, Philadelphia, PA)
Purpose: Enhance client participation in agency policy development and ownership of their own recovery processes.
Service Elements: 1) weekly Consumer Council meetings with, 2) Monthly Consumer Recognition Day, 3) *Recovery Focus*, a bi-monthly consumer council newsletter, 4) consumer peer mentor program (peer mentor assigned to all new clients), 5) consumer volunteer program (outreach and community service work), 6) Community Living Program (a consumer-directed recovery skills training and recovery coaching program delivered to men residing in the NET Wharton Center, an inpatient residential rehabilitation program), 7) The NET Community Recovery Center (a consumer-operated drop-in center), and 8) the consumer speakers bureau .
Service Volume/Status: Since its creation in August 2006, 90%+ participation from 14 revolving CC representatives; average of 120 consumers at monthly consumer recognition dinner.

Service Outcomes: Increased daily attendance rates, completion rates and successful rates of transfer to another level of care; decreased power struggles between clients and staff; greater client involvement in treatment.
Service Lessons: Empowering clients increases personal motivation for recovery and also increases motivation for professional staff; outreach moves recovery into the life of the community.
For More Information: Joseph Schultz (jschultz@net-centers.org)

There are also some very good models for Alumni Associations, a few of which are profiled in: White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC

Resource: The Net Consumer Council, Evans, A.C., Lamb, R.C., Mendelovich, S., Schultz, C.J. & White, W.L. (2007). The Role of Clients in a Recovery-oriented System of Addiction Treatment: The Birth and Evolution of the NET Consumer Council. I will email this paper to Jennifer and David for distribution.

5. Have you seen treatment systems that have made effective use of paraprofessionals or the public recovery community, while minimizing some of the obvious pitfalls? Has any standardized model of training for a paraprofessional Coach or Community Recovery Partner been designed?

There is a resurgence in recruitment of recovering people in paid and volunteer roles to provide peer-based recovery support services within addiction treatment organizations. There is also the growing phenomenon of private, fee-based recovery coaching offered most commonly by interventionists.

There are some recovery coach training manuals (See www.bhrm.org) and there are some effective training programs being launched as part of recovery-focused systems transformation efforts or offered privately—sometimes for outlandish fees.

Program Profile #: Peer Leadership Academy (PLA, Philadelphia, PA)[1]
Purpose: To train individuals and family members in recovery to assume leadership roles in Philadelphia's recovery-focused systems transformation process
Elements: 26 week training program
Service Volume/Status: effort spans recovery from addiction, mental illness and co-occurring disorders; 60 individuals have been trained by four faculty members; College credits are provided for completion of training.
Outcomes: survey of graduates revealed a total of 740 hours of voluntary community service in past 9 months—a 40% increase over pre-training levels; graduates reporting a total of 40 community presentations made since completion of training.
Lessons Learned: 1) increase in volunteer hours seems to be related to increased self-confidence of graduates, 2) PLA has provided a pool of effective volunteers to serve on key recovery advisory committees in Philadelphia, 3) quality of committee participation has increased in tandem with their skills, confidence and assertiveness, 4) having volunteers intern with committees provides great preparation for full membership on committees, 5) positive feelings of graduates toward the PLA is now the primary recruitment vehicle for new recruits.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

[1] Personal communication with Bev Haberle, December 2008

Resource: White, W. (2006). *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity.* (Monograph) Philadelphia, PA: Philadelphia Department of Behavioral Health; White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.
I can email these two papers to anyone who would like copies.

6. What is meant by "social marketing of AOD problem-resolution options and successes," specifically the term "social marketing"?

"Social marketing" as I have used the term is a strategy aimed at elevating community knowledge about and attitudes toward addiction recovery. Key messages here are that long-term recovery is a reality in the lives of millions of individuals and families, that there are many pathways to recovery, that recovery thrives in supportive communities, and that recovery gives back to individuals, families and communities what addiction has taken. Note: These campaigns are not primarily about addiction or about treatment; they are about RECOVERY, and include such information as the prevalence of recovery; religious, spiritual and secular pathways to recovery, the role of treatment in recovery, styles of recovery, stages of recovery, how others can support recovery, etc.
Resource: White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care,* 3(1-2), 21-61.

7. To overcome the myths of "cure," and the medicalized acute treatment episode, don't you think that programs and professionals will need to revamp the entire conceptualization of treatment, and change a lot of terminology?

Absolutely. As we shift from pathology models (addiction) and intervention models (treatment) to solution models (recovery), there are words we will need to cast aside (e.g., "aftercare") and a whole new lexicon that will come into common use, e.g., recovery management, recovery oriented systems of care, recovery priming, recovery capital, recovery planning, recovery coach, peer-based recovery support services, to name just a few.
Resource: White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services;
White, W. (2002) An Addiction Recovery Glossary: The Languages of American Communities of Recovery. www.facesandvoicesofrecovery.org; also included in: White, W. (2006). *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

8. What are the first five things you would do as a program director to begin promoting this concept or perspective of treatment at your facility.

My first 5 list might change depending on which day you asked me, but I'm sure these 5 would always be in my top 10.

1. Create a Recovery Advisory Board, including alumni, current consumers, and recovery community representatives (individuals and family members) to guide the agency transformation process.

2. Orient (over a period of months) all board members, staff, consultants and volunteers to research findings on long-term recovery and the recovery management model.
3. Create an internal task force to conduct a "fearless and searching" inventory of all clinical practices to evaluate their relevance to long-term recovery and to develop a plan to achieve more recovery-focused policies and practices.
4. Develop protocol for assertive linkage to local communities of recovery and monitor fidelity to such protocol by all staff.
5. Develop a program for post-treatment monitoring, stage appropriate recovery education, recovery coaching, and, when needed, early re-intervention for all clients admitted to treatment—with saturated support in first 90 days following primary treatment and at least annual recovery check-ups spanning the first 5 years of recovery.

Resource: White, W. (2005). Recovery Management: What if we <u>really</u> believed addiction was a chronic disorder? *GLATTC Bulletin*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, September, pp. 1-7.

9. Research on the most effective lengths for Recovery Management programs for adults.

We have reliable data only for adults on the question of, "When is recovery stable and durable, e.g., when does sobriety today predict lifelong sobriety? The key window of stability (point at which the risk of future lifetime relapse drops below 15% is between 4-5 years, although the relapse rate after 5 years is higher in recovery from opiate dependence that for alcohol dependence, suggesting monitoring (recovery checkups) for some groups might be indicated beyond 5 years..

Resource: De Soto, C.B., O'Donnel, W.E., & De Soto, J.L. (1989). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research*, *13*, 693-697. Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*(3), 243-249. Nathan, P., & Skinstad, A. (1987). Outcomes of treatment for alcohol problems: Current methods, problems and results. *Journal of Consulting and Clinical Psychology*. *55*, 332-340. Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, *20*(4), 771-779. Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J., & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol, 59*, 640-646. Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, *31*(6), 585-612. Schutte, K., Byrne, F., Brennan, P., & Moos, R. (2001). Successful remission of late-life drinking problems: A 10-year follow-up. *Journal of Studies on Alcohol 62,* 322-34.

For the higher risk of opiod relapse after five years, see: Simpson, D.D., & Marsh, K.L. (1986) Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims, & C. Luekefeld, *Relapse and recovery in drug abuse* (NIDA Monograph 72). Rockville, MD: National Institute on Drug Abuse. Hser, Y.I., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508.

10. Is Peer lead better vs staff lead?

If by peer, you mean recovery, there is no evidence that recovering people versus non-recovering people differ in effectiveness performing the same clinical functions. Such effectiveness differs greatly from individual to individual but is not determined either by recovery status or education.

If by peer, you mean other clients in treatment, there is almost no research on this question.

I suspect we will find in both areas that recovering staff without extensive professional training and treatment peers can play a significant role in attraction, engagement, enhancing retention and providing experience-based advice on long-term recovery decision-making and that traditional professionals not in recovery will play three critical roles: assisting as they do now with the process of biopsychosocial stabilization, treating co-occurring medical and psychiatric disorders, and then, interestingly, offering guidance well into the recovery process on character reconstruction and the reconstruction of family and intimate relationships. In short, the question will change from, "Are recovery peers or professional staff more effective in influencing recovery outcomes?" to "Which roles are superior for what functions and at what particular stages of recovery.

Resource: White, W. (Drafted, release in spring 2009). *Peer recovery support: History, theory, practice and scientific findings*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

11. What's the most effective Adolescent Recovery Management research and effective programs.

I'm partial to the Adolescent Community Reinforcement Approach because it addresses intrapersonal, interpersonal and environmental dimensions of adolescent recovery, attempts to create a recovery-conducive post-treatment milieu, and incorporates very assertive approaches to post-treatment continuing care.

Resource: Godley, M.D., & Godley, S.H. (in press). Continuing care following residential treatment: History, current practice, and emerging approaches. In N. Jainchill (Ed.), *Understanding and treating adolescent substance use disorders*. Kingston, New Jersey: Civic Research Institute; Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21-32; Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, *102*, 81-93; Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behaviors, 19*(1), 62-70; Godley, S.H., Dennis, M.L., Godley, M.D., & Funk, R.R. (1999). Thirty-month relapse trajectory cluster groups among adolescent discharged from out-patient treatment. *Addiction*, *99*(Suppl 2), 129-139; Godley, S. H., Godley, M. D., & Dennis, M. L. (2001). The assertive aftercare protocol for adolescent substance abusers. In. E. Wagner, & H. Waldron, (Eds.), *Innovations in adolescent substance abuse interventions* (pp. 311-329). New York: Elsevier Science Ltd.

For information on assertive linkage of adolescents to recovery support groups, see: Passetti, L. L., & White, W. L. (2007). Recovery support meetings for youths: Considerations when referring young people to 12-step and alternative groups. *Journal of Groups in Addiction and Recovery*, 2, 97-121.

12. What are your recommendations regarding specific methods on connecting assessments, treatment planning and placement levels of adults versus teens.

My primary interests in this area have been on helping my colleagues develop a comprehensive assessment instrument (the GAIN) and how we transition from staff directed treatment plans to client-directed recovery plans. As for linking assessment and placement levels, I have been investigating the interaction of problem severity/complexity and recovery

capital should influence level of care placement and intensity and duration of in-treatment and post-treatment recovery support services. I am particularly interested in how the assessment of community recovery capital could enhance placement and recovery planning decisions.
Resource: White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor,* 9(5), 22-27; White, W., Kurtz, E. & Sanders, M. (2006). *Recovery Management*. (Monograph) Chicago, IL: Great Lakes Addiction Technology Transfer Center. For info on the GAIN, See www.chestnut.org.

13. What is your view of benefits and liabilities of community-based treatment, such as wrap-around for teens versus segregated residential treatment?

I think wrap around models are effective strategies for creating multi-agency, interdisciplinary teams to address the needs of multiple-problem adolescents and families. Two deficiencies of these models are that they 1) tend to only focus on the integration of formal professional agencies and neglect indigenous healers and indigenous institutions that can be critical to long-term recovery, and 2) they have a tendency to emphasize coordination and case management without an adequate focus and dose on primary treatment. Regarding point 2, I have seen clients with 4 case managers but no one doing primary treatment. The strength of the better of these models I have evaluated is in engagement and problem stabilization; their weakness is in assuring adequate recovery initiation (a lot of so-called relapse is more aptly described as continued drug use; relapse can't occur until after a period of recovery initiation) and sustaining support through the transition from recovery initiation to recovery maintenance and enhanced quality of life in long-term recovery.
Resource: White, W. (in press). The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.

14. As more communities are shifting funding away from adolescent residential settings and replacing it with wrap-around, what is your viewpoint or your specific positions on the longer-term consequences of such decisions?

This shift will meet the needs of adolescents/families presenting with low/moderate problem severity and moderate/high recovery capital, but will fail markedly with adolescents/families presenting with high problem severity/complexity and low recovery capital. The long-term consequence will be that the adolescents in this latter groups will be abandoned to systems of control and punishment. And they will be blamed for failing to respond to structures whose service intensity and duration provided no likelihood of successful recovery initiation and maintenance. That process has already been underway since the heightened restigmatization, demedicalization and criminalization of AOD problems since the "zero tolerance" philosophy of the 1980s.
Resource: White, W. (in press). The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.

15. I would ask what Bill has seen, through his experience and research, as the most effective components of recovery management in the community for adolescents following short or long term residential treatment as well as youth who have participated in outpatient care.

I have seen a wide variety of such components. My favorite include:

- the earlier-noted system of recovery checkups
- recovery community development strategies that seek to increase young peoples meetings and sober social activities

- special linkage procedures to recovery support groups (See Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs, 40*, 29-40.)
- recovery support groups in schools—often delivered through student assistance programs
- recovery schools
- recovery homes for adolescents
- (There is much discussion about the potential of telephone- and internet-based recovery support services for adolescents.)

Resource: White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor,* 7(2), 54-58; Godley, S. & White, W. (2006). Student assistance programs: A valuable resource for substance-involved adolescents. *Counselor,* 7(2), 66-70; White, W. (Drafted, release in spring 2009). *Peer recovery support: History, theory, practice and scientific findings*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

16. In your view what is the best way to collect outcome data once clients leave treatment?

Clinical and research follow-up rates used to be so awful that we followed mostly those who didn't need it and collected data on samples completely unrepresentative of the whole. The really good news is that the field has developed very sophisticated strategies for maintaining almost indefinite contact with people following treatment. At Chestnut's research division, we routinely maintain 90%+ follow-up rates in studies following clients for up to 10 years following treatment. These approaches, which rely on very ingenious locator systems, maintaining regular contact with people even between follow-up interviews, incentivising continued contact on the part of the client, etc, have also been extensively described (See Scott & Dennis article below). I think the best approaches use rigorous collection and updating of locator data, use multiple follow-up media (face-to-face, mail, phone and internet), and assign trackers to locate clients who cannot be contacted via routine methods.

Resource: Scott, C. K., & Dennis, M. L. (2000). A cost-effective approach to achieving over 90% follow-up in outcome monitoring with substance abuse treatment clients. *Drug and Alcohol Dependence*, *60*(Suppl. 1), s200.

17. With recovery support services such as AA/NA being adult oriented, what do you view as the best recovery support activities for adolescents?

Passetti and Godley studied adolescent treatment center referral processes to recovery support groups and found the highest rates of successful linkage within programs that:

- emphasized the sober social activities sponsored by support groups (e.g., young peoples' conferences),
- worked with local support group service structures to identify particular meetings appropriate for young people,
- identified individuals to serve as role models and guides for young people,
- created networks of trusted people to accompany young people to meetings,
- monitored post-treatment attendance and response to meetings, and
- helped identify potential sponsors.

Little is known about the role of mutual aid factors other than meeting attendance on long-term adolescent recovery outcomes, e.g., having a sponsor, having a home group, step-work, etc.,

and even less is know about the role of participation in other recovery support institutions, although preliminary data on recovery schools looks very promising.

Resource: Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs, 40*, 29-40.

18. What is the most useful recovery support program you have witnessed?

There are few things that can match recovery mutual aid groups in terms of geographical accessibility, availability (24/7/365) and affordability (free). If a program director said I have a small amount of money to do only one thing—What should that one thing be (other than assertive linkage to mutual aid groups)? I would answer, "Invest in post-treatment recovery monitoring and recovery coaching for all clients during the first 90 days following discharge (regardless of discharge status.)

Resource: Scott, C. K., Dennis, M. L., & Foss, M. A. (2005a). Recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, *78*, 325-338; Scott, C. K., & Dennis, M. L. (in press). Results from two randomized clinical trials evaluating the impact of Quarterly Recovery Management Checkups with adult chronic substance users. *Addiction*.

19. In our community-based women's programs, we ask that residents identify a "mentor" from the community who is a resource/support during their treatment episode and who will continue that role when she exits treatment. We have a broad definition of "mentor", including 12-step sponsor, church member, advocate, or other community member who agrees to accept that role. We require that this person come into the program for an interview with clinical staff prior to formalizing the relationship in the client's treatment plan. What comments/recommendations regarding this approach would you have?

I like this a lot. I think what we are seeking is long-term continuity of contact in a primary recovery support relationship as the glue that meshes all the other services and service relationships that are part of this thing we call treatment. Ideally that continuity of support spans pre-treatment engagement, in-treatment support, and post-treatment monitoring and support.

Resource: For scientific studies of sponsorshio, mentor programs, and "companionship therapy", see White, W. (Drafted, release in spring 2009). *Peer recovery support: History, theory, practice and scientific findings*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

20. What is your experience of faith-based systems as the extended recovery support plan?

There are religious, spiritual and secular frameworks of long-term recovery and all constitute legitimate pathways of recovery. We do not have data on the proportion of the total recovery population across these three broad categories. What is clear is that faith based recovery is on the increase, as evidenced by:

- "Recovery friendly churches" that welcome recovering people but offer no special recovery services
- Churches spawning new religiously sponsored recovery mutual aid groups, e.g., Celebrate Recovery, Victorious Ladies
- Mega-churches adding a "recovery pastor" to their staff
- Small churches using lay leaders and volunteers to lead recovery support meetings

- Church-sponsored, recovery-focused worship services, workshops, leadership training, and children's programs
- Recovery Churches, e.g., Central Park Recovery Church in St. Paul, Minnesota, the Recovery Church in Charlotte, North Carolina, and the Christian Recovery Fellowship in Dryden, Maine, for whom recovery is a central part of their identities as religious communities
- New faith-based recovery colonies (residential communities), e.g., Dunklin Memorial Camp in Okeechobee, Florida
- A new association of recovery ministries, i.e., the National Association for Christian Recovery (http://www.nacronline.com), and
- The growth of non-Christian recovery ministries and support groups, e.g., Millati Islami.

I think one of the most important contributions of faith-based recovery communities is the idea that recovery for some people comes not through incremental stages but as a climactic experience that is unplanned, positive and permanent—experiences that have their religious, spiritual and secular varieties. I think we need to know a lot more about how to recognize such experiences and guide these powerful recovery initiation experiences into sustainable long-term recovery.

Resource: White, W. & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor.* 6(5), 58-62; White, W. (2004) Transformational change: A historical review. *IN SESSION: Journal of Clinical Psychology,* 60(5), 461-470; White, W. (2004) Transformational change and addiction recovery. *Counselor*, 5(4), 30-32.

21. How do we engage the staff in the transition from the TC to long term rehabilitation using an empowering and strength based focus versus negative reinforcement/consequences?

I think this shift will need to occur over a period of years and, of course, has actually already begun via training on things like stages of change and motivational interviewing. This transition will accelerate as we get better strengths-based assessment instrument and recovery planning instruments and protocol.

22. What evidence based practices are you familiar with that are effective in treating addiction?

There are several good registries of such practices and web sites (see http://www.samhsa.gov/ebpwebguide/appendixA_Across.asp; http://www.nattc.org/resPubs/bpat/docs/Presentations/introebp.ppt#412,7,Evidence-Based Practices for Alcohol Treatment; http://www.nattc.org/resPubs/bpat/index.html;
And sites that provide manuals related to such practices (See www.bhrm.org and the adolescents treatment manuals posted at www.chestnut.org as samples.

23. Define and differentiate "recovery oriented care" and "reality of recovery"?

Recovery-oriented care is a term encompassing service designs whose elements are linked to intermediate and long-term recovery outcomes, e.g., therapeutic alliance, service dose, assertive linkage to communities of recovery, assertive approaches to post-treatment monitoring and support. Reality of recovery is a phrase most often use to call for a vanguard of recovering people and their families to step forward to offer themselves as living proof of the “reality of long-term recovery”—a social antidote to the “once a junkie, always a junkie” myth deeply buried in drug cultures and the culture at large.

"The general assumption is that, the greater the problem severity and complexity, the greater the restrictiveness and potential duration of treatment but comprehensive assessments of recovery capital can alter such decisions considerably"(p. 57) ....Please explain the term "Recovery Capital" and how it impacts the level of care.

24. Recovery management, how is that differ to a continuum of care?

Continuum of care is a treatment concept that delineates the beginning (identification, screening, assessment, intake, engagement), middle (service menu across multiple levels of care) and end (discharge planning, discharge and brief “aftercare”) of professional care. Recovery management is a broader conceptualization of the role of treatment in the long-term recovery process, e.g., destabilization of addiction, pre-recovery engagement, recovery initiation and stabilization, recovery maintenance and enhanced quality of personal/family life in long-term recovery. COC is measured in days, weeks, and (at best) months; RM is measured in years and focused on liking multiple interventions to shorten addiction careers and lengthen recovery careers.

25. At what point (if any) do we say no when we look at the term "revolving door"?

This is an agonizing question in the RM model. The critical question is this: Is our continued engagement of this client enhancing or inhibiting recovery initiation and maintenance? How would we know this? Measurable evidence toward recovery stabilization and success transitioning from recovery initiation to recovery maintenance, e.g., lapse/relapse episodes are decreasing in frequency, intensity, duration and consequences and periods of recovery are lengthening and characterized by growth in personal, family and social recovery capital. Another criteria: When the individual is readmitted, are they working on recovery or "doing time"—the latter renders treatment a milestone in one's addiction career, not a milestone in a recovery career.

26. Can he give Long Island team concrete examples of how to create a peer support group for our recent and long term alumni? Based on his research, what does he recommend in terms of frequency of meetings?

Utilize a leadership development strategy that recruits indigenous leaders, engages a larger pool of clients/alumni via (focus groups, needs assessment processes, interests inventories). The purposes, activities, meeting frequencies, etc. should be defined by consumers/alumni and allowed to rapidly evolve over time as needed.

For an example of a long-term group, see

Profile of a Vibrant & Enduring Recovery Alumni Association
Group: Discovery (Alumni Association of New Day Center at Hinsdale Hospital, Hinsdale, IL) Founded: Early 1980s Founded by: John Daniels (aftercare director) and two graduates and their spouses. Membership Size: Ranged between 250-500 over past ten years Duration of Participation: 30-40% have participated for more than 5 years with some of founding members still participating Meeting Frequency: Monthly social events and 2-3 organizational meetings each year Social Event Activities: Potlucks, dinners out, bowling, weekend trips Average Event Attendance: 60-70 Distinctiveness / Keys to Success: Involvement of partners/spouses and children; development of long-term relationships with individuals/families in recovery; autonomy of group from treatment organization (New Day only provides space and assistance with mailings) Membership Fee: $5 per person per year Association Assets: Approximately $10,000 used to support activities and participation of any members who cannot afford activities. Greatest Challenge to Date: Engaging and retaining adolescents after treatment. Source: Interview with Don Malec, Discovery Leader, 630-240-1215.

For info on early needs assessment process, contact Bev Haberle at Philadelphia's Recovery Community Center 215-262-5771

Also see earlier profile of NET Consumer Council—one of best I have ever seen.

27. What resources or literature can he recommend for the family support group (non-professional) on recovery management?

Family-oriented models of RM are just developing. For a discussion of these and excerpts from family support group members, see White, W. & Savage, B. (2005). All in the family: Alcohol and other Drug Problems, Recovery, Advocacy. *Alcoholism Treatment Quarterly,* 23(4), 3-38. Posted at http://www.facesandvoicesofrecovery.org/resources/publications_white.php

28. Under the new model of recovery management, is it considered appropriate to maintain contact or initiate phone/email contact with clients who have completed treatment? In the past, this was taboo. For example, would setting up Yahoo group chat board (or something of the like) for alumni be within the realms of what is permissible and appropriate?

Yes and yes! But this is not at the whim of individual staff—such sustained contact is part of an established protocol and continued post-treatment contact with clients occurs within and only within this protocol. Shifting from an acute psychotherapy model to a model of long-term recovery support requires a rethinking of ethical boundaries in service relationships: compare this with the differences in definitions of appropriateness between emergency room nurses and hospice nurses or nurses doing home-based management of advanced diabetes. This does not mean that we throw everything away; but it means that we must redefine actions that are always okay, never okay and sometimes okay and sometimes not okay (and define the difference). (BTW, these definitions are often different by role, e.g., clinician versus recovery coach.) In the new world of RM, the latter category of sometimes is much larger, requiring a much greater emphasis on professional and peer supervision. Some of this is also just common sense—the recognition that in some cultural contexts greater harm can occur to multiple parties from refusing a gift than could occur from accepting that same gift.

See White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services. Posted At:
http://www.facesandvoicesofrecovery.org/resources/publications_white.php

29. How are other traditional therapeutic community program adapting in the movement away from confrontation and humiliation and other iatrogenic practices and in the movement towards evidence-based practices?

David may be in a better position to answer this one than me. What I have done is focus on the history of such practices in the TC and the larger treatment world and collaborated with Bill Miller to interpret the scientific evidence on so-called "therapeutic confrontation." (See White, W. & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, 8(4), 12-30.) I considered this article a form of amends to the field for my role in promoting confrontation as a therapeutic approach early in my clinical career.

Having been on the receiving and delivering ends of such confrontations and "learning experiences" since the late 1960s, here is how I make sense of this today. Confrontation was an essential tool in suppressing attitudes and behaviors that could corrupt a therapeutic milieu & may still serve this function. How do you suppress what we long called "dope fiend" behaviors in a community of addicts fresh off the streets? That requires mechanisms that can strip such behavior, inculcate new and extremely clear community norms, and enforce those norms on a

daily (and minute-to-minute) basis. I think confrontation was one of the tools that did this. But the larger question of whether such confrontation/humiliation actual has therapeutic properties is a quite different one, and the best evidence we have is that it has no such therapeutic effects and may be quite harmful, particularly with particular populations (See above citation for review of this literature).

I think we need to help the TC evolve as a whole by constructing its own recovery story that tells how it was, what happened that sparked change in key elements of TC practices, and what the TC is evolving toward today. David and I have talked a lot about the fact that "confrontation" involved many ingredients in the early TCs and took place in a particularly long-term relational context between individuals and between an individual and the TC family as a whole. The effects that we once attributed to the many forms in which confrontation occurred may have had more to do with the care, concern and acceptance that followed in the aftermath of such confrontations than in the act of verbal confrontation, shaving someone's head or putting a sign or diaper on them. I would be interested in hearing from all of you about how you think TCs are evolving on this issue.

30. Other than the checklists from the Tools of Transformation website, what kind of strengths-based assessment would you recommend to do "intakes" and assess recovery "outcomes" in a voluntary recovery management/continuing care type program? Are there any "validated" instruments that are not pathology based?

The development of such instruments and protocol are part of an important national recovery research agenda, but some progress is being made. The Global Appraisal of Individual Need (GAIN) (See www.chestnut.org) now has some beginning measures of recovery capital built into them, and their were no less that 4 proposals to NIDA & NIAAA this past 6 months proposing the development of recovery-focused instruments. I have also been working on some simple recovery capital checklists that can be used as recovery planning tools. I will try to get these emailed for possible distribution to all of you.

THANKS EVERYONE FOR ALL THE WONDERFUL QUESTIONS! FEEL FREE TO EMAIL OR CALL IF YOU HAVE FOLLOW-UP QUESTIONS.



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Citation: Titus, J.C. & White, W.L. (2009). Substance use among youths with hearing loss: A primer for student assistance professionals. Student Assistance Journal, 20(3), 14-18. Posted at **www.williamwhitepapers.com**

Substance Use among Deaf and Hard of Hearing Youths: A Primer for Student Assistance Professionals

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Over the past 40 years, the number of deaf[1] and hard of hearing students educated in public school settings rather than in specialized schools for the Deaf has increased dramatically. Gallaudet University's Annual Survey of Deaf and Hard of Hearing Children and Youth reports that in the 2006-2007 school year, 64.8% of deaf and hard of hearing students were "mainstreamed" with hearing students at least 1 hour per week, with 43.9% mainstreamed for at least 16 hours per week. As a result, student assistance professionals are increasingly being called upon to respond to the special needs of deaf and hard of hearing students. These needs include responses to a wide spectrum of problems, including problems related to alcohol and other drug use.

This article 1) reviews the latest survey data on substance use among deaf and hard of hearing students, 2) summarizes the profile of students with hearing loss who are experiencing serious substance-related problems, 3) offers suggestions on what student assistance professionals can do to enhance their effectiveness working with substance-involved deaf and hard of hearing students, and 4) identifies key sources of information that may aid this helping process.

Hearing Loss and Substance Use Prevalence and Problems

Students who are hard of hearing constitute the majority of mainstreamed students with hearing loss. Although they have a certain degree of useable hearing, these students often do not fully understand spoken communication, even with the help of hearing aids. In contrast to hard of hearing students, deaf students are unable to use their hearing for communication purposes. In order to participate in regular education classrooms, deaf and hard of hearing students often depend on such support services as interpreters, preferential seating, and notetakers.

Research on the prevalence of alcohol and other drug use among deaf and hard of hearing youths is exceedingly scant and methodologically weak. For many years, substance-related problems among deaf

people were characterized as “uncounted, unreached, untreated” (Boros, 1981). Existing studies paint an inconsistent picture, but most researchers agree that the prevalence of alcohol and drug use among deaf and hard of hearing people is at least as prevalent as that among hearing people.

In addition to the usual risk factors found in the youth population, deaf and hard of hearing students face additional issues related to substance use. These factors include:

- limited family discussion and social learning about the dangers of drug use;
- decreased exposure to formal prevention programs, more so for deaf than hard of hearing youth;
- decreased access to family and extended family support (the majority of children with hearing loss have hearing parents, and not all families choose to learn or become proficient in sign language);
- disability-related effects on self-esteem and identity development;
- increased emotional distress related to social isolation and struggles to connect with a hearing world;
- enablement by the non-disabled population, resulting in a sense of entitlement to substance use because of disability-related limitations and estrangement from others; and
- a deep need to fit in with hearing and non-hearing peers, including students who use alcohol and other drugs (Dick, 1996; Gallaudet Research Institute, 2007; Guthmann & Sandberg, 1998; McCrone, 1982; Oliva, 2004).

These special risk factors seem to produce greater problem severity among deaf and hard of hearing students who go on to develop substance-related problems. This pattern is evident in the largest study to date of youths with hearing loss entering addiction treatment in the United States (Titus, Schiller, & Guthmann, 2008). In this study, deaf and hard of hearing youth and hearing youth shared many characteristics, but the former were found to be distinguished by six critical factors:

1. lower age of onset of substance use;
2. greater substance problem severity (dependence and withdrawal);
3. higher rates and greater severity of childhood victimization;
4. higher rates of co-occurring psychological problems (depression, traumatic stress, conduct problems);
5. social networks more dominated by substance users; and
6. greater likelihood of past running away from home or being homeless.

All of the above factors have been identified as obstacles to long-term recovery, suggesting that deaf and hard of hearing students who have substance problems may require treatment of greater intensity and post-treatment recovery support services of greater duration.

Assessment, Treatment and Recovery

Assessment and treatment of substance use disorders among youths and adults with hearing loss have not progressed much in recent decades. Report recommendations prepared in the 1970s and 1980s about the need for improved accessibility and quality of addiction treatment are as relevant today as when they were first written. Several specialized addiction treatment programs for deaf and hard of hearing people identified various issues that need to be addressed when providing services to this population. Adaptations of these recommendations as they apply to youths are as follows.

Assessment Students with stronger English literacy skills and less severe hearing losses may be able to complete a written or orally administered English language substance abuse assessment with few to no accommodations. However, for students with severe to profound losses, an English language assessment may not be

appropriate. The average reading comprehension of deaf 17 and 18 year olds is at the 4th grade level (Gallaudet Research Institute, 1996), and language used on substance abuse assessments can be more advanced than that. In this case, a signed assessment is required. There are numerous challenges to signed assessments, even when administered by qualified interpreters. First, there is only one signed alcohol/drug screening instrument[2] (Alexander, 2005) and no diagnostic instruments validated for deaf and hard of hearing people. In addition, the language of substance abuse is replete with English colloquialisms and concepts that do not have clear translations to sign language (e.g., "black out"). There is a fair amount of regional variability in signs for particular words (e.g., six signs for "hangover"). The Deaf community is small and members are well informed of what is going on in each others' lives, so confidentiality is at stake for students who have ties to this culture (Alexander, DiNitto & Tidblom, 2005; Guthmann, & Sandberg, 1998). Screening and assessment is best done in collaboration with persons possessing a knowledge of Deaf culture.

Resource Mobilization Young people with hearing loss in need of treatment for substance-related problems can find themselves trapped between three worlds—a school, an addiction treatment agency, and an agency serving the Deaf, all of whom feel they lack the expertise needed to address this combination of problems and circumstances. One of the roles the student assistance professional can serve in this situation is that of convener—bringing multiple agencies together to facilitate the assessment, treatment and long-term recovery support process.

Professional Treatment There are very few addiction treatment resources tailored specifically for deaf and hard of hearing individuals and only a handful of programs. Thus, most deaf and hard of hearing youths who could benefit from culturally and linguistically adapted treatment do not receive it. Deaf and hard of hearing youths are most often treated in hearing programs with the aid of interpreters, many of whom may not be sufficiently qualified to function effectively in addiction treatment settings. It is vitally important that hearing counselors who provide treatment to deaf and hard of hearing youths have a working knowledge of Deaf culture as well as an understanding of the impact a hearing loss can have on an individual who must function in a hearing world. There is some consensus that mainstreaming youths with hearing loss into addiction treatment may be more acceptable for those who experienced hearing loss later in life, possess some oral communication abilities, and do not strongly identify with Deaf culture (Guthmann & Graham, 2004). Thus far, there have been no randomized trials comparing the relative effectiveness of treating deaf and hard of hearing youths in a segregated program versus in a program with hearing youths.

In spite of the above-noted obstacles, research on post-treatment recovery rates of deaf and hard of hearing people are equivalent to those of their hearing peers (Moore & McAweeney, 2007). A study of a specialized addiction treatment unit for Deaf and hard of hearing youth and adults found that improved recovery outcomes were related to three factors: 1) attendance at recovery support groups such as Alcoholics Anonymous and Narcotics Anonymous, 2) having family members support sobriety efforts, and 3) being employed (Guthmann, 1996; Guthmann & Blozis, 2001).

Recovery Support Resources Integrating recovery into a sustainable lifestyle is a particular challenge for deaf and hard of hearing people of any age. The community of people with hearing loss is small, and existing substance-focused relationships may be the only significant social relationships in the individual's life. Hearing loss may pose obstacles to developing recovery supports in the hearing community, and recovery-focused role models and relationships among other deaf people may be non-existent or limited (Rendon, 1992). Few options exist for culturally and linguistically accessible recovery resources, especially for youths. A notable exception can be found in some larger communities,

where Deaf-run recovery groups such as Alcoholics Anonymous operate. Some hearing recovery groups have interpreter support, though the cost of an interpreter can be a barrier. Internet-based recovery communities provide a source of support for deaf and hard of hearing individuals with adequate English skills. Some recovery homes accept deaf adult clients and several sign language recovery homes have been established. A recent evaluation of an Oxford House recovery home found it to be an effective alternative for deaf individuals seeking support for recovery (Alvarez, Adebanjo, Davidson, et al, 2006). These resources may prevent post-treatment isolation and lower the risk of relapse in encounters with prior relationships based on substance use. Options specifically targeted to youths, though, are lacking.

Prescriptions for Student Assistance Professionals

Given this review of what we know about substance-related problems among deaf and hard of hearing students, how can the student assistance professional respond to the needs of these students? We propose the following nine suggestions:

1. Remain aware of how hearing-loss-related issues may present themselves, e.g., isolation, wanting to fit in with hearing peers, attempts at "passing," impaired parent-child communication, low self-esteem, and entitlement to excessive behavior.
2. Learn as much as you can about Deaf culture and the variations in how people with hearing loss relate to Deaf culture.
3. Seek consultation with agencies servicing individuals with hearing loss and agencies for the Deaf.
4. Identify local/regional resources for substance-involved students who are deaf or hard of hearing.
5. Learn how to collaborate with qualified interpreters, e.g. speaking to the student rather than the interpreter, establishing confidentiality guidelines, debriefing.
6. Create an acoustical environment conducive to communication with hard of hearing students, e.g., provide enhanced lighting, minimize background noise and visual distractions, remain facing the student when speaking, maintain eye contact, enunciate each word clearly, avoid covering your mouth with your hand.
7. Capitalize on prevention and early intervention opportunities with deaf or hard of hearing students that focus on information dissemination and issues of social isolation, adjustment to hearing loss, and family distress.
8. Link students with serious substance use problems to specialized resources for assessment, treatment, and peer-based recovery support using assertive linkage procedures, e.g., physically linking the student to the resources versus providing a name and verbal encouragement to go.
9. Conduct on-going recovery check-ups either at regular intervals or at times identified to be particularly high risk for relapse.

Suggested Reading, Resources, and Websites

- 12 steps recovery resources for deaf and hard of hearing individuals - http://www.dhh12s.com/accessdeafhoh.htm
- Chestnut Health Systems' list of addiction treatment resources for people with hearing loss - http://www.chestnut.org/LI/APSS/Common/Multicultural/D-HH_Resources.pdf
- Communication tips for working with deaf and hard of hearing individuals - http://www.michdhh.org/hearing/comm_tips.html
- Communication tips for working with sign language interpreters – http://www.sfgov.org/site/mod_page.asp?id=42215
- Curriculum package on substance abuse in the Deaf and hard of hearing community available

through the mid-Atlantic ATTC - http://www.mid-attc.org/order%20forms/ProductOrderForm4_2_08.doc

- Gina Oliva's book on isolation among hard of hearing children in the mainstream - Oliva, G. (2004). *Alone in the Mainstream*. Washington, D.C.: Gallaudet University Press.
- List of resources on mainstreaming children with hearing loss – http://deafness.about.com/go/dynamic/offsite.htm?zi=1/XJ&sdn=deafness&cdn=health&tm=45&gps=153_866_1020_558&f=22&su=p726.2.152.ip_p284.8.150.ip_&tt=2&bt=0&bts=0&zu=http%3A//clerccenter.gallaudet.edu/InfoToGo/096.html
- Marc Marschark's comprehensive book on deaf children – Marschark, M. (1998). *Raising and educating a deaf child*. New York: Oxford University Press.
- Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals – www.mncddeaf.org
- National Clearinghouse Catalog – Addressing the Chemical Health Needs of Deaf and Hard of Hearing Individuals - http://www.mncddeaf.org/pages/clearinghouse_catalog.pdf
- National Directory of Alcohol and Other Drugs Prevention and Treatment Programs Accessible to the Deaf - http://www.rit.edu/studentaffairs/counseling/saisd/national_directory/nat.directory.htm
- Northwest Deaf Addiction Center - http://www.lifelineconnections.org/home/dac.shtml
- Videos, workbooks, and DVDs for use with deaf and hard of hearing substance abusers, including an anti-tobacco curriculum aimed at teens - http://www.mncddeaf.org/pages/materials.htm

Footnotes

[1] It is customary when referring to people with hearing loss to distinguish between the terms "deaf" and "Deaf". Although subtly different in appearance, their connotations reflect two very different world views of what it means to have a hearing loss. The term "deaf" describes an audiological hearing loss and is associated with the medical model of deafness, which views hearing loss as a disability. The term "Deaf" is associated with the cultural model of deafness, which views deaf people as a language minority – a community of people with a shared language, history, social norms, traditions, and values who happen to not hear. Those who provide services to people with hearing loss are advised to be aware of the difference between these terms and anticipate how one's identification as deaf or Deaf could interact with service provision.

[2] Efforts are currently underway to create a second substance abuse screening instrument that is validated and normed on a Deaf and hard of hearing population. The Substance Abuse in Vocational Rehabilitation-Screener in American Sign Language (SAVRS-S-ASL; Guthmann & Moore, 2007) is an ASL translation of the Substance Abuse Subtle Screening Inventory (3rd edition) (SASSI-3; Miller, Roberts, Brooks, & Lazowski, 1997). The project is being led by Dr. Debra Guthmann of the California School for the Deaf – Fremont and Dr. Dennis Moore of Wright State University.

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Acknowledgments

The authors wish to thank Dr. Debra Guthmann of the California School for the Deaf-Fremont and Mr. James Schiller of Gallaudet University in Washington, D.C. for their review and comments on the preliminary draft of this article.

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Addiction as a Chronic Disorder: Key Messages for Clients, Families and Referral Sources

William L. White, MA and A. Thomas McLellan, PhD

Modern medicine has recognized that chronic diseases cannot and should not be treated and managed like acute disorders.

Acute disorders such as bacterial infections, broken bones and even emotional trauma from shock or injury, can typically be traced to a clearly identifiable source (e.g., an infectious agent, physical trauma) and can be "cured" through treatment and recovery processes that span a relatively short period of time. The onset, course and resolution of acute disorders may be intense and disruptive, but they generally leave no lasting mark on one's identity or functional capabilities. The treatment process essentially returns the body to its original state - the treated individual is no more (or less) susceptible to a return of the disease or condition than an individual who never had the disease. Thus, while a treated individual may again break a bone or get another infection - this is considered a new occurrence and not a relapse.

In contrast, chronic diseases such as diabetes, asthma or heart disease spring from and are complicated by, multiple biological, psychological and social factors - some of which cannot be clearly identified. Many times "lifestyle" or personal behavioral choices are intimately involved in the onset and course of these disorders. While there are usually several potentially effective treatments for chronic disorders, they are of necessity more complex and protracted than acute treatments and they do not produce the same kinds of outcomes as acute treatments.

All chronic treatments, regardless of disease, share three important features. First, they can usually remove or reduce the symptoms of the disease - but cannot affect the root causes of the disease. For example, beta blockers reduce blood pressure and insulin improves the body's ability to digest sugars and starches - as long as the affected individual continues the treatment. However, these treatments do not return the affected individual to normal.

The second feature associated with all chronic treatments is that they require significant changes in lifestyle and behavior on the part of the patient

to maximize their benefit. Again, even if individuals with diabetes regularly takes their insulin as prescribed, this will not stop disease progression if they do not also reduce sugar and starch intake, increase exercise and reduce stress levels.

The third feature derives from the first two. Because of the complexity of factors that can lead to a chronic illness and because of the need for ongoing medical care and lifestyle change, it should not be surprising that relapses are very likely to occur in all chronic illnesses. For these reasons, most contemporary treatment strategies in chronic illness involve regular in-person and/or telephone monitoring of medication adherence; coupled with encouragement and support for pro-health changes in diet, exercise and stress levels. Increasingly, family members are being trained to also provide continuing monitoring and support for the behavioral changes necessary to maintain symptom remission and sustain good quality of life. .

As is evident from this short preface, the onset and course of chronic illnesses are not like those of acute illnesses; and for these reasons chronic care has to be quite different from acute care. While many in our field have come to consider some (not all) forms of addiction as chronic - this change in thinking has not been followed by changes in treatment strategy, monitoring methods, insurance coverage or outcome expectations. With this as background, the current article: 1) summarizes the history of the conceptualization of severe alcohol and other drug dependence as a chronic disease, 2) updates the scientific evidence comparing alcohol and drug dependence to diabetes mellitus, hypertension and asthma, and 3) identifies the central messages that addiction professionals can communicate to clients, families and referral sources regarding addiction treatment and long-term recovery management strategies.

Historical Background

The earliest conceptualizations of chronic drunkenness as a medical condition by Drs. Benjamin Rush and Thomas Trotter were followed by more substantive treatises by Drs. M. Huss, W. Marcet, T.D. Crothers and others, all of whom noted the prolonged course of alcohol dependence and the professional challenges involved in its treatment. The origins of terms such as *habituation*, *inebriety*, *dipsomania*, *alcoholism* and *addiction* were rooted in efforts to convey a condition far more complex and enduring than the threat posed by an episode of acute alcohol or other drug intoxication. The recognition of the chronicity and complexity of severe alcohol and other

drug problems led to the calls for special institutions for the care of the inebriate (Woodward, 1838) and the subsequent birth of inebriate homes, inebriate asylums and private addiction cure institutes (White, 1998).

There were several early pioneers who suggested that the treatment of addiction should mirror the treatment of other chronic diseases. In 1828, Dr. J.H. Kain penned an essay on the treatment of intemperance in which he invoked the medical maxim, "chronic diseases require chronic cures" (p. 295). Dr. T.D. Crothers expressed similar sentiments in an 1879 editorial in the *Journal of Inebriety*:

> *The permanent cure of inebriates under treatment in asylums will compare favorably in numbers with that of any other disease of the nervous system which is more or less chronic before the treatment is commenced.* (p.249)

Such comparisons of addiction to other chronic disorders were lost in the larger collapse of the inebriate asylum movement in the opening decades of the twentieth century.

As interest in alcoholism as a public health problem arose again in the mid-twentieth century, alcoholism was again compared to other chronic diseases. A 1938 report of the Scientific Committee of the Research Council on Problems of Alcohol concluded, "An alcoholic should be regarded as a sick person, just as one who is suffering from tuberculosis, cancer, heart disease, or other serious chronic disorder" (Johnson, 1973, p. 244). Also worthy of note is a 1947 article by Dr. R.E. Duncan published in the *Kansas City Medical Journal.* Duncan declared that alcoholism is a "chronic affair" and that "chronic conditions must be approached on a long range basis." He further concluded, "to foster complete recovery, treatment must be continued for years after the patient has been sobered" (pp.11-12). Duncan was one of the first practitioners to explore the full clinical implications of the chronicity of addiction. During this same period, Charles Franco, an early industrial alcoholism pioneer, wrote a 1951 article "Chronic Alcoholism as a Medical Problem in Industry." He called for recognizing alcoholism "as much a disease as diabetes or tuberculosis." (Duncan, 1951, p. 48)

One other important historical footnote from the mid-twentieth century was the 1942 publication of Howard Haggard and E.M. Jellinek's *Alcohol Explored*. In this text, which was overshadowed by Jellinek's later book *The Disease Concept of Alcoholism* (1960), Haggard and Jellinek suggest that "The progress of research has been impeded by two conceptions: the first that all habitual excessive drinking is a disease, and the

second that it is the same disease" (p.143). This statement anticipated much of the later debate over the question of whether alcoholism is a disease and whether all alcohol problems can comfortably fit within a "disease" or "chronic disease" rubric. Our focus in this article is not on what addiction is—a disease, illness, disorder, habit, problem, etc.—but on the temporal course of addiction and how the span of the disorder from onset through sustained recovery can be most effectively managed at personal and professional levels.

Treatment in an Acute Care Model

The emphasis on alcoholism as a chronic disease was lost in the larger battle to convey to the American public and policy makers that alcoholism was a disease (Mann, 1944). This effort spanned the 1940s-1960s and led to landmark legislation in 1970 that set the stage for the rise of community-based, time-limited addiction treatment in the United States. This was followed by a rapid process of professionalization and commercialization and subsequent emergence of an aggressive system of managed behavioral health care in the U.S. Despite (or perhaps because of) these forces, nearly all modalities of addiction treatment migrated toward an acute care (AC) model of intervention--even traditionally long-term modalities such as therapeutic communities and methadone maintenance.

The AC model is characterized by the following central elements:

- Services are delivered "programmatically" in a uniform series of encapsulated activities (screening, admission, a single point-in-time assessment, treatment procedures, discharge, and brief "aftercare" followed by termination of the service relationship).
- A professional expert directs and dominates the assessment, treatment planning and service delivery decision-making throughout this process
- Services transpire over a short (and historically ever-shorter) period of time -usually as a function of a pre-arranged, time-limited insurance payments designed specifically for addiction disorders and "carved out" from general medical insurance..
- The individual/family/community is given the impression at discharge ("graduation") that "cure has occurred:" long-term recovery is now self-sustainable without on-going professional assistance.

- Post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the individual rather than potential flaws in the design or execution of the treatment protocol.

By the later 1990s, the assumptions of the AC model began to be questioned (O'Brien & McLellan, 1996; Hser, Anglin, Grella, et al, 1997; Stout, Rubin, Zwick, et al, 1999). These early critiques were followed by widespread calls to extend the design of addiction treatment from an AC model to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002; Godley, Godley, Dennis, et al, 2002; Dennis, Scott & Funk, 2003; Compton, Glantz, & Delaney, 2003; White, 2005; McKay, 2005; Dennis, Scott, Funk, & Foss, 2005; Scott, Dennis, & Foss, 2005; Flaherty, 2006; Dennis & Scott, 2007). One call to redesign addiction treatment was the publication of "Drug Dependence, a Chronic Medical Illness" in the *Journal of the American Medical Association* (McLellan, Lewis, O'Brien & Kleber, 2000). In the next section, we will summarize and update the major findings of this seminal article.

Addiction as a Chronic Medical Illness

It is important to state at the outset that not all alcohol- and drug-related (AOD) problems inevitably become chronic disorders; and that clinical research has not yet been able to clearly predict which early cases will ultimately become chronic. Many substance use problems are developmental and as such are often outgrown in the successful transition from adolescence into adulthood. Others occur in tandem with major life transitions (e.g., death of a loved one, divorce, job loss) and are resolved by time, natural support, brief professional intervention or peer-based intervention by others in recovery (Burman, 1997; Granfield & Cloud, 1999, Bien, Miller & Tonigan, 1993; Bernstein, Bernstein, Tassiopoulos, et al, 2005). Similarly, many of those who experience a period of high blood pressure will essentially get over this problem through change of lifestyle, loss of weight and increased physical activity. It is not currently possible to predict who will go on to develop chronic hypertension.

For many reasons, most of those entering addiction treatment are characterized by greater personal vulnerability for AOD problems (e.g., family history of AOD problems, early onset of AOD use, traumatic victimization), greater problem severity (e.g. substance dependence), greater problem complexity (e.g., concurrent medical/psychiatric illness, multiple

drug use), and fewer personal and family resources to initiate and sustain a long-term recovery process (Bischof, Rumpf, Myer, et al, 2004; Granfield & Cloud, 1999). There are striking similarities between substance dependence as seen in the clinical setting and other chronic illnesses such as 2 diabetes mellitus, hypertension and asthma (McLellan, Lewis, O'Brien & Kleber, 2000). Severe substance dependence and these other primary chronic illnesses:

- Are influenced by genetic heritability and other personal, family and environmental risk factors.
- Can be identified and diagnosed using well-validated screening questionnaires and diagnostic checklists.
- Are influenced by behaviors that begin as voluntary choices but evolve into deeply ingrained patterns of behavior that, in the case of addiction, are further exacerbated by neurobiological changes in the brain that weaken volitional control over these contributing behaviors..
- Are marked by a pattern of onset that may be sudden or gradual.
- Have a prolonged course that varies from person to person in intensity and pattern.
- Are accompanied by risks of profound pathophysiology, disability and premature death.
- Have effective treatments, self-management protocols, peer support frameworks and similar remission rates, but no known cures.

These similarities between serious substance dependence and other chronic illnesses are striking. It is important to note that even substantial similarity does not mean that similar disease processes are at work across these conditions. However, at the very least, the similarities argue for consideration of the same kinds of chronic or continuing care strategies for alcohol and drug dependence that have been employed in other chronic diseases. If substance dependence *is like other chronic illnesses*, then this raises two important implications: 1) acute care models of intervention for severe substance dependence may reduce substance use temporarily but those reductions are not likely to sustain once care stops; and 2) methods used in the treatment of other chronic illnesses might be effectively adapted to enhance long-term recovery from substance dependence. These

implications offer an explanation of the generally high and rapid rates of relapse following cessation of most available addiction treatments (McLellan et al., 2000): there is simply no quick fix for the most severe forms of this disorder.

Changes in Service Infrastructure and Practices

Recent years have been marked by pilot efforts to move addiction treatment beyond the acute biopsychosocial stabilization and patient education toward the goal of long-term recovery as measured by stable sobriety, global (physical, emotional, relational, spiritual) health and citizenship (Betty Ford Institute Consensus Panel, 2007). Efforts to create "recovery-oriented systems of care" are underway at national, state and local levels (Clark, 2007; Kirk, 2007; Evans, 2007).

However, it should be obvious at this point that elevating long-term recovery rates for severe substance dependence will require fundamental changes in the national, state and local infrastructure of addiction treatment as well as changes in front-line service practices (Roman & Johnson, 2002; D'Aunno et al., 1998; McLellan, Carise & Kleber, 2003) and service relationships (McLellan et al., 2005). Table 1 illustrates the direction of desired infrastructure changes that addiction professionals can anticipate if the field can muster the collective will and resources to affect such changes.

Table 1: Infrastructure Changes Required for Shift toward Recovery Management

Element of Service Infrastructure	**Change Required**
Operational Stability, Leadership Development & Succession Planning	Increased continuity of ownership & leadership of addiction treatment programs; a new generation of leaders committed to recovery-focused system transformation, replacement of the current mass exodus of long-tenured leaders at all levels and across all roles in the field.
Institutional Mission, Core Values & Service Philosophy	Shift in focus from acute stabilization to long-term individual (and ideally) family recovery; articulation of core recovery values that will drive system transformation processes; integration of clinical models of intervention with public health and community development models that seek to alter the

	community recovery environment.
Policy-making Processes	Diverse representation of people (individuals/families) in recovery at all levels of system decision-making.
Service Integration / Holistic Care	Development of multi-agency, interdisciplinary, cross-trained teams and integrated funding streams. Integration of primary medical and psychiatric care within specialized addiction treatment settings - and vice versa.
Funding Philosophies and Mechanisms	Shift by government and private sources from purchasing time, or session-limited units of service - to purchasing an integrated program of management and support for long-term recovery; shift in emphasis from treatment intensity (crisis stabilization) to treatment extensity (prolonged recovery maintenance)
Regulatory Standards and Monitoring Protocol	Integration of chronic care principles into monitoring standards; shift from focus on program policy development and procedural efficiency to intermediate and distal recovery outcomes.
Workforce Preparation & Stabilization	Greater emphasis on recovery principles and processes in preparatory education and training; new training programs for peer-based recovery support specialists (e.g., recovery coaches); initiatives seeking to lower turnover of service personnel to achieve continuity of contact in recovery support relationships.
System Relationships	Shift from paternalism to partnership—from hierarchical control to reciprocal respect.
Information Technology	Computer-based clinical management information systems capable of evaluating individual, unit and organizational performance based on key recovery indicators.
Evaluation & Research	All treatment providers will monitor and report aggregate recovery outcome data at regular intervals for all those receiving care; funding of state and national recovery research agendas, e.g., detailed recovery prevalence data, documentation of long-term pathways and styles of recovery.

In the shift from an acute care to recovery management model, changes in local programmatic and service practices will be required in several critical areas. These changes will focus on such treatment system performance indicators as the following (White, Boyle, Loveland, 2003; Evans, 2007; White, in press):

- Attraction: identifying and engaging individuals and families at an earlier stage of AOD problem development (e.g., via assertive community education, screening and outreach programs)
- Engagement: enhancing access, therapeutic alliance, and retention (e.g., expedited service initiation, focus on relationship-building and regular re-motivation, altered policies related to administrative discharge)
- Assessment: developing assessment protocols that are global, family-centered, strengths-based and continual.
- Service Planning: transitioning from professional-developed treatment plans to client-directed recovery plans.
- Service Menu: Focusing on service elements that have measurable effects on recovery outcomes; expanding the service menu to include non-clinical, peer-based recovery support services.
- Service Duration: Shifting from "emergency room" models that emphasize brief, crisis-oriented services to "recovery models" that emphasizes long-term, lower intensity recovery maintenance services.
- Service Location: Extending the reach of services from the institutional environment to the natural environments of individuals and families, e.g., expansion of neighborhood-based, work-based and home-based services.
- Service Relationship: Shifting from a professional expert model to a long-term recovery partnership/consultant model; philosophy of choice for individuals and families.
- Continuing Care: Shifting from "aftercare" as an unfunded afterthought to assertive models of continuing care for all clients (regardless of discharge status), e.g., post-treatment monitoring, stage-appropriate recovery education and coaching, personal linkage to communities of recovery and, when needed, early re-intervention. Expanded use of cell phones and Internet for long-term monitoring and support.
- Relationship to the Community: Increasing utilization of indigenous recovery support resources in the community, e.g., recovery support groups, recovery community organizations (e.g., recovery support

Communicating about Addiction as a Chronic Disease

Many communications about addiction and especially communications comparing it to other chronic illnesses can arouse strong feelings and unintended, harmful implications. Because of the significant family and social problems associated with addictive disorders, strong feelings are aroused when these conditions are discussed as "illnesses" or "chronic diseases." To many in the public at large this represents inappropriate "medicalization;" abrogation of personal responsibility for those affected; and a ready-made excuse for ineffective treatment for the treatment field. Perhaps worse, many individuals with substance use disorders who have gained and maintained recovery may resent the idea that they have a "continuing chronic illness."

Thus, care must be taken in how the chronic nature of addiction is communicated to the policy makers and the public, clients, family members, referral sources and to those working on the front lines of addiction treatment. In the service of better communication we first discuss what this concept of addiction as a chronic illness does NOT imply; followed by ten concepts and correlates that may be helpful in thinking about and discussing appropriate and effective continuing care for chronic forms of this illness.

<u>Things NOT Implied or Suggested by the Concept of Addiction as a Chronic Illness</u>

- All AOD problems are NOT chronic, most do NOT have a prolonged and progressive course - some do and research is needed to identify early signs of chronic progression.
- All persons with AOD problems do NOT need specialized, professional, long-term monitoring and support - many recover on their own, with family or peer support; again research is needed to identify who is most likely to need intensive, professional care.
- Among those who do need treatment, relapse is NOT inevitable and all persons suffering from substance dependence do NOT require multiple treatments before they achieve stable, long-term recovery.
- Even among those who do relapse following treatment, families, friends, and employers should NOT abandon hope for recovery. (Community studies of recovery from alcohol dependence report long-term recovery rates approaching or exceeding 50% Dawson, Grant, Stinson, et. al., 2005).

- Having the serious chronic illness of addiction, DOES NOT reduce personal responsibility for continuous efforts to manage that illness - just as those with serious diabetes or hypertensive disease must also manage their illnesses.
- Appropriate treatment for chronic addiction is NOT simply a succession of short term detoxifications or treatment stays. Appropriate continuing care requires personal commitment to long term change, dedication to self management, community and family support and monitoring.
- Current addiction treatment outcomes are NOT acceptable simply because they are comparable to those achieved with other chronic disorders.

Things that ARE Important In Considering the Concept of Addiction as a Chronic Illness

- Chronic Diseases Vary. Not everyone at risk for a chronic disease contracts the disease or experiences the same course of the disease. Chronic diseases exhibit a high degree of variability in pattern of onset, course and intensity (self-accelerating, constant, alternating cycles of remission and relapse, or decelerating). Each case of chronic disease varies in physiological severity, functional impairment, and the financial/emotional burden placed on the individual, family and society (Stein, et al, 1987). The course of chronic disorders is influenced by the interaction of such factors as type and degree of biological vulnerability, age of onset, problem severity, problem complexity (e.g., presence of co-occurring disorders) and degree of individual, family and community *recovery capital* (assets that can be drawn upon to initiate and sustain recovery) (Granfield & Cloud, 1999). Adding to the burden of chronic disorders is their propensity to beget other acute and chronic disorders such as depression and chronic pain.

- Chronic diseases require prolonged and active management. Chronic disorders require strategic, sustained stewardship of personal, family and community resources. Core strategies for achieving long-term recovery from chronic disorders include stabilization of active episodes, global assessment, enhancement of global health, sustained professional monitoring and early re-intervention, continuity of contact in a primary recovery support relationship, and development

- Both full and partial recoveries are possible. There are permanent solutions to severe alcohol and other drug problems. Millions of individuals and families throughout the world live full lives in long-term recovery from these problems. Their increasingly public stories, even more than the accumulation of scientific studies, offer living proof of this proposition. Partial recoveries are also possible. An essential strategy of chronic disease management is optimizing personal functioning and quality of life even after abstinence has been achieved. Recovery management strategies for persons with the most severe and persistent disorders include multiple goals: reducing the number, intensity, and duration of relapse episodes; strengthening and extending the length of remission periods; reducing the personal and social costs associated with relapse; reducing the propensity for drug substitution and other excessive behaviors during early periods of recovery initiation; and enhancing the quality of personal/family life through both the remission and relapse phases of the disorder. Partial recovery may constitute a prelude to resumed substance dependence, a permanent state, or a stage of ambivalence and instability that precedes the achievement of full recovery.

- Recovery processes vary. There are multiple pathways, patterns and personal styles of long-term recovery (White & Kurtz, 2006). The time and resources required to fully resolve alcohol and other drug problems vary from individual to individual. Greater time and resources are often required as substance use disorders become more severe and complex and as a personal, family and community recovery capital diminish. Beyond this general guideline, there is no way to predict who will sustain recovery following a single effort, who will achieve recovery after multiple efforts or who will fail to achieve recovery.

- Lapses after recovery initiation are common but not inevitable. A lapse (episode of alcohol or drug use) or relapse (resumption of compulsive use and its related problems) following treatment does not mean that there is no hope for recovery. A significant portion of

- Natural support matters, The prospects of long-term recovery for individuals are enhanced by sustained family and social support. Family members and friends can take concerted action to shorten a loved one's addiction career (the span of time from problem onset to stable recovery maintenance) and to enhance the health of all family members and the family unit.

- Intervening early makes a difference. Recognizing and intervening in the alcohol and other drug problems of a family member can shorter his or her addiction career. There are brief windows of opportunity within the course of addiction that can be capitalized upon to help initiate and solidify long-term recovery.

- Personal and family recovery take time. Some of the personal/family problems that preceded or that developed after the onset of alcohol and other drug problems continue into the early years of recovery. The resolution of these problems requires time, sustained effort, and, quite often, professional help.

- Professional and peer support helps. Individual and family recoveries are enhanced by sustained professional and peer support. Monitoring the status of a chronic disease, the effectiveness of the efforts to manage it, and changing physical, psychological, behavioral and environmental risk factors are crucial elements in chronic disease management. Sustained participation in peer-based recovery support groups and other recovery community institutions (e.g., recovery homes, recovery schools, recovery ministries) can elevate long-term recovery rates. Primary physicians, addiction professionals and other frontline health care providers constitute and important resource for long-term recovery check-ups and support.

- Recovery is a marathon that can bring unexpected gifts. Recovery from severe alcohol and other drug problems, like recovery from other primary health problems such as diabetes, asthma or heart disease,

A Historical Opportunity

Re-engineering addiction treatment into a system of sustained recovery support will be both a major challenge and an important opportunity for society. We invite those on the frontlines of addiction treatment to join us in writing this new future for addiction recovery in America.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2008). Why addiction medicine? John P. McGovern, MD Award acceptance speech, American Society of Addiction Medicine, Miami, Fl, April 28. Journal of Addictive Diseases, 27(3), 3-5. Posted at **www.williamwhitepapers.com**

Why Addiction Medicine?[1]

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Medicine's cultural ownership of severe alcohol and other drug (AOD) problems has been historically granted on only a probationary status. That ownership was revoked in the opening of the 20th century amidst a weakening of the field's infrastructure and public pessimism about the prospects of long-term addiction recovery. When America's first network of inebriate homes and asylums and private addiction cure institutes collapsed, a new generation of recovery advocates and addiction medicine pioneers rose from the ashes of that collapse. These individuals spent their entire lives changing cultural attitudes and forging new social policies that birthed modern addiction treatment. We owe a great debt to the vision, courage and tenaciousness of these men and women. The resurrected system of addiction treatment is again facing internal and external threats to its character and its future.

In the face of such threats, it is important to periodically ask why this country needs a specialized field of addiction medicine and a specialized arena of addiction treatment. My greatest fear is that the larger field of addiction treatment will disappear amidst the illusion of its continued presence. This could occur if we were colonized by more powerful forces in our operating environment in ways that corrupted our core values and service technologies. Given this threat, it is important to define for ourselves, for our communities and for the individuals and families we serve precisely what dimensions of addiction medicine and addiction treatment are distinct from all other health and social service interventions. Each of us would bring different perspectives to this question. For me, that distinctive essence rests in nine kinetic ideas from which the central actions of the field flow and that form a thread of historical continuity through which the field was birthed and has evolved.

Proposition One: Substance use disorders spring from multiple etiological roots and vary in their severity, complexity,

[1] . Excerpted from the John P. McGovern, MD Award Lecture, American Society of Addiction Medicine, Miami, Fl, April 28, 2007.

duration and outcome. It is such variability that calls for advanced and specialized training, skilled differential diagnosis and highly individualized approaches to service planning and delivery. A specialized field of addiction treatment would not exist but for the failure of other disciplines to adequately understand and effectively treat severe and prolonged substance use disorders.

Proposition Two: Addiction is a primary disorder and primarily a disorder of the brain. The addictions treatment field rests on the belief that, even when spawned by other conditions, substance use disorders achieve a level of independence that requires direct and specialized treatment. Addiction has long been characterized as a disease of the will, and recent scientific breakthroughs within our field confirm the biological roots of this incapacity to just say no. The essence of addiction treatment is not the temporary reversal of the physical, psychological or social consequences of addiction. It is found instead in the sustained amelioration of the rabid appetite that is the source of such destruction. A central rationale for our field's existence is that addiction recovery is best facilitated by practitioners who can distinguish addiction disease from the biopsychosocial consequences of alcohol and other drug use and who can offer their patients tools through which they can reclaim their health and their powers of personal decision-making.

Proposition Three: Well-intentioned but uninformed attempts to treat substance use disorders can result, and have resulted, in significant harm to individuals and families (1). The history of such iatrogenic insults spans coerced and prolonged institutionalization, mandatory sterilization procedures, invasive psychosurgeries, convulsive therapies, and drug insults that are incomprehensible by today's standards. The latter include lethal bromide therapies used for narcotic withdrawal, methamphetamine injections prescribed as a treatment for heroin addiction, and prescriptions of amphetamines and barbiturates as a treatment for alcoholism. One of the most fascinating accounts from my historical research is an 1889 medical journal report on the cure of a female morphine addict using two and one half pounds of prescribed cocaine. The journal account reported that the patient was "much encouraged" and "had ordered two pounds" more. The cure was confirmed by the account that the last time the physician saw the patient she assured him that she no longer had any desire whatsoever for morphine (2). It is easy to look at such treatments through the retrospective lens of history and self-righteously proclaim, "What were they thinking?" But history teaches that it is very difficult to recognize such insults in one's own era. This bodes humility and caution and the need for specialized training for those charged with treating addiction.

Proposition Four: Addiction recovery is a reality in the lives of millions of individuals and families. Addiction medicine is founded on a deep belief in this reality, the importance of vividly conveying hope for full recovery to individuals and families, and the willingness to offer sustained guidance through that process. Other fields of medicine and social services witness the devastation of addiction. Addiction medicine is unique in its practitioner's ability to witness close up the transformative power of long-term recovery. A close connection to the recovery experience is the source of the hope that permeates our best service milieus.

Proposition Five: There are multiple pathways and styles of long-term recovery. These pathways encompass religious, spiritual and secular frameworks of recovery that vary widely across cultural context (3). All are cause for celebration. These pathways are reflected in the growing diversity of addiction treatments and peer-based recovery support structures in the United States. What we offer at our best are practitioners who possess a deep knowledge of and a deep respect for these diverse pathways and styles of recovery.

Proposition Six: Addiction recovery is more than the removal of alcohol and drugs from an otherwise unchanged life. The achievement of global health, or wellness, as an outcome of recovery is best achieved

within a framework of treatment that focuses on the whole person/family (4). Facilitating the attainment of global health within the recovery process requires knowledge of the far-reaching influences of addiction, the stages of recovery, and the zones of action and experience within which recovery unfolds. That core knowledge and those core skills exist in no other professional field.

Proposition Seven: Recovery maintenance is a distinctly different process than recovery initiation. Brief biopsychosocial stabilization should not be mistaken for stable recovery maintenance. Such respites are as likely to mark milestones in a long addiction career as they are the beginning of a recovery career. We are perhaps the only profession that doesn't take pride in how good an addicted person can look after a month of supervised sobriety. The understanding of recovery as an enduring process underscores the importance of sustained monitoring and support, stage-appropriate recovery education and, when needed, early re-intervention—all provided by practitioners with an intimate knowledge of the long-term recovery process.

Proposition Eight: Addiction recovery is not durable until it is nested in the community—within the physical and cultural environment of each patient/family. Many patients with severe substance use disorders are deeply enmeshed in cultures of addiction that have come to dominate their lives. Recovery is an intrapersonal journey, but it can also be a journey from a culture of addiction to culture of recovery. The latter is reflected in the proliferation of Twelve Step groups and adjuncts and alternatives to such groups. The potential role of peer support groups in the recovery process suggests the need for specialists familiar with the organizational structures, core concepts, catalytic metaphors, meeting rituals and cultural etiquette of these groups. It suggests the need for professionals who are skilled at matching and linking patients and families to these resources. Addiction specialists are distinguished by their knowledge of addiction, but even more so by their knowledge of the physical and social ecology of recovery.

Proposition Nine: Addiction medicine is founded on an empowering relationship that is free of contempt and moral censure, that is characterized by emotional authenticity and candor, and that is focused on the strengths and resiliencies of each individual and family. In contrast, those with severe alcohol and other drug problems have historically been greeted by other social institutions and professional helpers with moral judgment, contempt, service exclusion or extrusion and power struggles that often ended in maltreatment. The addictions field is also unique for its "wounded healer" tradition. More than any allied field of health and human services, we have a deep respect for the value of experiential knowledge. That knowledge transcends the issue of one's personal recovery status. We have long contended that the personality and life experiences of each practitioner constitute potent ingredients of therapeutic alliance and therapeutic outcomes. That degree of emphasis on use of self in the healing of others has few precedents in the history of medicine.

These nine propositions—perhaps most notable for their simplicity--and the distinct clinical practices that flow from them distinguish addiction medicine and the larger arena of addiction treatment from all other helping institutions and professions. Amidst the wave of service integration initiatives, it is important that these core ideas and service technologies not be lost.

We are in a unique position in this most unusual of occupations. We have the ability to both treat soul-corrupting illness and to witness individuals and families redefine themselves at a most fundamental level. In our best moments, we get to witness people rise from a state of utter despair to develop a quality of life and a level of citizenship and service that is sometimes spellbinding. There is nothing more sacred in this profession than the privilege of being part of such transformations. When we strip away all the organizational, professional, financial and regulatory structures, it is this

unique human encounter and what we bring to it that distinguishes our field.

If the field should ever lose its way, if it should ever be abandoned to those who view alcoholics and addicts only as a crop to be harvested for financial profit, it is this power to touch and transform lives and these distinct ideas and service practices that will need to be rediscovered in the future. We each have a responsibility and role in protecting that legacy.

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Citation: White, W. (2009) Addiction medicine in America: It's birth and early history (1750-1935) with a modern postscript. In R. Ries, D. Fiellin, S. Miller, & R. Saitz, Eds. *Principles of Addiction Medicine, 4th Edition*, American Society of Addiction Medicine. Baltimore: Lippincott Williams & Wilkins, Chapter 22, pp 327-334. Posted at **www.williamwhitepapers.com**

Addiction Medicine in America: Its Birth and Early History (1750-1935) with a Modern Postscript

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The recent recognition of addiction medicine as a medical specialty obscures the fact that American physicians have been involved in the treatment of severe and persistent alcohol- and other drug-related problems for more than two centuries. This article describes the birth of addiction medicine in the late 18th century, the professionalization of addiction medicine in the second half of the 19th century, and the virtual collapse of addiction medicine as an organized specialty in the opening decades of the 20th century. The review includes early pioneers of addiction medicine, conceptual and clinical breakthroughs, the evolving settings in which addiction medicine was practiced, the larger currents in American medicine, and the evolving social policies that influenced the early practice of addiction medicine.

The Birth of Addiction Medicine

The roots of addiction medicine began not in a young America but in the ancient civilizations of Africa and Europe. Special methods to care for those addicted to alcohol were developed in ancient Egypt, and references to chronic drunkenness as a sickness that enslaved body and soul date to Heroditus (fifth century BC), Aristotle (384-322 BC), and Seneca (4 B.C.-65 AD). St. John Chrysostom (1st Century, AD) provided one of the earliest comparisons of chronic alcohol inebriety to other diseases (1). These earliest intimations of the concept of addiction and its treatment reflect the fleeting observations of individuals rather than an organized cultural response to alcohol and other drug problems.

The earliest American medical responses to alcoholism emerged within the systems of medicine practiced by Native American tribes. Alcohol-related problems rose dramatically in Native America as alcohol became increasingly used as a tool of economic, political, and sexual exploitation in the 18th and early 19th centuries (2, 3). Native tribes actively

resisted these problems through political/legal advocacy, organizing sobriety-based cultural revitalization movements, and through the medical treatment of those affected. Native American healers used botanical agents to suppress cravings for alcohol (hop tea), to induce an aversion to alcohol (the root of the trumpet vine), and to facilitate personal transformation within sobriety-based cultural and religious revitalization movements (4).

In Colonial America, there was pervasive consumption of alcoholic beverages, but no recognition of excessive drinking as a distinct medical problem (5). This changed in response to increased alcohol consumption (a near tripling of annual per capita alcohol consumption between 1780 and 1830), a shift in preference from fermented to more potent forms of distilled alcohol, and the emergence of a pattern of socially disruptive "frontier drinking" (6, 7). It was in this changing context that several prominent Americans "discovered" the phenomenon of addiction (8).

In 1774, the philanthropist and social reformer Anthony Benezet published a treatise entitled *Mighty Destroyer Displayed* that recast alcohol from its status as a gift from God to that of a "bewitching poison." He noted the presence of "unhappy dram-drinkers bound in slavery" and observed that drunkenness had a tendency to self-accelerate: "Drops beget drams, and drams beget more drams, till they become to be without weight or measure" (9).

Benezet's warning was followed by a series of publications by Dr. Benjamin Rush (1746-1813). Rush's work is particularly important given his prominence in Colonial society and his role in the history of American medicine and psychiatry. Rush's 1784 pamphlet, *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body,* was the first American treatise on alcoholism, and it almost single-handedly launched the American temperance movement. In this pamphlet, Rush catalogued the symptoms of acute and chronic drunkenness, described the progressiveness of these symptoms, and suggested that chronic drunkenness was a "disease induced by a vice" (10). Rush was the first prominent physician to claim that many confirmed drunkards could be restored to full health and responsible citizenship through proper medical treatment and to call for the creation of a special facility (a "Sober House") to care for the drunkard (11).

Rush's writings were mirrored in the work of physicians in other countries, most notably the Edinburgh physician, Dr. Thomas Trotter, whose 1788 publication, *Essay, Medical Philosophical, and Chemical, on Drunkenness and its Effects on the Human Body,* shared many of Rush's ideas (12). Another contribution that influenced the subsequent development of addiction medicine in America was the work of Christopher Wilhelm Hufeland, who in 1819 described a clinical condition characterized by uncontrollable cravings for alcoholic spirits that triggered periodic "drink storms." Hufeland labeled this condition *dipsomania*. During the same decade, Lettsom, Armstrong, and Pearson described the condition that Thomas Sutton subsequently christened *delirium tremens* (13).

By the late 1820s, the subject of chronic drunkenness was taken up in a number of medical dissertations. Most notable among these were the works of Drs. Daniel Drake and William Sweetser. Drake speculated on the causes of "habitual drinking," elaborated on Rush's list of systems of the body effected by alcohol, and hinted at what would later become the concepts of *inability to abstain* and *loss of control* ("...the habit being once established, he will not, I almost say cannot, refrain") (14). In 1828, Sweetser provided a detailed account of the pathophysiology of chronic alcohol intoxication, including depictions of the addictiveness of alcohol and the potential role of heredity in chronic drunkenness. He concluded that intemperance created a "morbid alteration" in nearly all the major structures and functions of the human body. Cycles of compulsive drinking were viewed by Sweetser as the product of a devastating

paradox: the poison (alcohol) was itself its only antidote (15).

The 1827 publication of the Reverend Lyman Beecher's *Six Sermons on the Nature, Occasion, Signs, and Remedy of Intemperance* exerted their own influence on the emerging concept of addiction. Bridging the gap between moral and medical models, Beecher described the intemperate as being "addicted to the sin" and suffering from an "insatiable desire for drink." Beecher provided two other contributions to this developing concept. First, he described the early warning signs of addiction, linking these to the later signs that Rush, Drake, Sweetser, and others had catalogued. Second, he challenged these very physicians who, in the case of Rush, had tried to get their patients to moderate their drinking by switching from distilled alcohol to fermented drinks such as wine or beer. Beecher's declaration, "There is no remedy for intemperance but the cessation of it" marked the call for complete abstinence as a personal and social strategy for the resolution of alcohol problems (16).

Between 1774 and 1829, America "discovered" addiction through the collective observations of her physicians, clergy, and social activists. There was an emerging view that chronic drunkenness was a problem with biological roots and consequences and thus the province of the physician. These earliest pioneers declared that chronic intoxication was a diseased state, and they articulated the major elements of an addiction disease concept: biological predisposition, drug toxicity, pharmacological tolerance, disease progression, morbid appetite (craving), loss of volitional control of alcohol/drug intake, and the pathophysiological consequences of sustained alcohol and opiate ingestion. While their treatments could involve such "heroic" methods as purging, blistering, bleeding, and the use of highly toxic medicines, they also used surprisingly modern strategies (e.g., aversive conditioning) and recognized many pathways to the initiation of sobriety, e.g., from religious conversion to witnessing an alcohol-related death. The writings of this period portray addiction recovery not as an enduring process but as a climactic decision. This view focused the attention of the emerging temperance movement on the pledge of lifetime abstinence (from distilled alcohol) as a central strategy in their early attempts at rescue work with confirmed drunkards.

Addiction medicine emerged in the shift from treating medical consequences of alcohol addiction to treating the addiction itself. The earliest practice of addiction medicine predated institutional treatment and was practiced out of the private offices of individual physicians. Alcohol was not the only drug of concern to these physicians. During the 16th and 17th centuries, physicians in Germany, Holland, Portugal, and England had begun to conceptualize opium as "a kinde of poison" that required regular and increasing use that, when stopped, created a unique sickness that drove people to return to the drug (17). In 1701, the English physician, John Jones, provided an exceptionally detailed account of opiate withdrawal in his book, *The Mysteries of the Opium Reveal'd* (18). Three events between the early and mid-nineteenth century profoundly altered the future of narcotic addiction in America: the isolation of morphine from opium, the introduction of the hypodermic syringe, and the emergence of a patent drug industry. These events produced drugs of greater potency, created a more efficient and euphorigenic method of drug ingestion, and increased the availability and promotion of powerful psychoactive drugs (19, 20).

Early Professionalization and Medical Advancements (1830-1900)

In 1828, Dr. Eli Todd, superintendent of the Hartford Retreat for the Insane, called for the creation of a physician-directed inebriate asylum. Under his influence, the Connecticut State Medical Society passed a resolution supporting this idea in 1830 (21). A year later, Dr. Samuel Woodward, Superintendent at the Hospital for the Insane at Worcester, Massachusetts, wrote a series

of influential essays echoing the Connecticut recommendations. He declared:

> *A large proportion of the intemperate in a well-conducted institution would be radically cured, and would again go into society with health reestablished, diseased appetites removed, with principles of temperance well grounded and thoroughly understood, so that they would be afterwards safe and sober men* (22).

Woodward argued that intemperance was a physical disease requiring medical remedies and, breaking with Rush, declared that "the grand secret of the cure for intemperance is total abstinence from alcohol in all its forms" (22). This total abstinence position was given greater weight in light of the failed efforts to cure drunkards through the use of public pledges to refrain only from distilled alcohol. The number of drunkards who continued their debauchery through fermented alcoholic drinks contributed to the temperance movement's shift from the partial pledge to the T-total pledge (23).

What followed in the 1830s and 1840s was a series of clinical contributions to the understanding of chronic drunkenness that exerted considerable influence on the emerging field of addiction medicine (24). First, there were new experiments and clinical observations on the pathophysiology of alcohol such as those of Prout, Beaumont, and Percy on the effects of alcohol on the stomach and the blood (25). Dr. Robert Macnish's *Anatomy of Drunkenness* (1835) offered one of the earliest typologies of alcohol addiction, noting seven clinical subtypes (26). Macnish also referenced a subject that continued as a medical controversy for much of the 19th century: the claimed spontaneous combustion of alcohol inebriates. (27, 28).

In 1838, France's leading expert on drunkenness, Dr. Esquirol, argued that the disease of intemperance was a "monomania"–a "mental illness whose principle character is an irresistible tendency toward fermented beverages" (29). This was followed in 1840 by Dr. R.B. Grinrod's text, *Bacchus*, in which he declared, "I am more than ever convinced that drunkenness is a disease, physical as well as moral, and consequently requires physical as well as moral remedies" (30, 31, 32).

One of the most significant milestones in the history of addiction medicine was the 1849 publication of Magnus Huss' text, *Chronic Alcoholism*. After an extensive review of the chronic effects of intoxication, Huss declared:

> *These symptoms are formed in such a particular way that they form a disease group in themselves and thus merit being designated and described as a definite disease...It is this group of symptoms which I wish to designate by the name <u>Alcoholismus chronicus</u>* (33, 34).

Huss' text stands as the landmark addiction medicine text of the mid-19th century. It contributed a clinical term–*alcoholism*–that came into increasing medical and public popularity in the transition between the 19th and 20th centuries.

The Washingtonian Revival of the 1840s and the fraternal temperance societies and reform clubs that followed brought the issue of recovery from alcoholism onto center cultural stage. Local Washingtonian groups encountering "hard cases" needing more than an occasional sobriety support meeting began organizing lodging houses that evolved into America's first addiction treatment institutions. A multi-branched treatment field emerged in the mid-19th century. Inebriate homes emerged out of alcoholic mutual aid societies that viewed addiction recovery as a process of moral reformation (35). There were medically-directed inebriate asylums, the first of which was the New York State Inebriate Asylum, chartered in 1857 and opened in 1864, under the leadership of Dr. Joseph Turner (36, 37). There were also privately franchised, for-profit addiction cure institutions such as the Keeley, Neal, Gatlin, and Oppenheimer Institutes. These

institutions generated considerable controversy over their claim to have medicinal specifics that could cure addiction (38) and their practice of hiring physicians who were in recovery from addiction (39, 40). Inebriate homes and asylums and the private addiction cure institutes competed with bottled patent medicine addiction cures (most containing alcohol, opium, morphine, or cocaine), some of which were promulgated by physicians, and religiously sponsored inebriate colonies and rescue missions (21). By the late 1870s, large urban hospitals, such as Bellevue Hospital in New York City, had also started opening inebriate wards (41). Annual alcoholic admissions at Bellevue rose to 4,190 by 1895–a number that continued to climb to more than 11,300 per year in the opening decade of the 20th century (21).

In 1870, Dr. Joseph Parrish led the creation of the American Association for the Cure of Inebriety (AACI), which brought together the heads of America's most prominent inebriate homes and asylums. The AACI by-laws posited that: *1. Intemperance is a disease. 2. It is curable in the same sense that other diseases are. 3. Its primary cause is a constitutional susceptibility to the alcoholic impression. 4. This constitutional tendency may be either inherited or acquired* (42). The AACI held regular meetings to exchange ideas and published the first specialized medical journal on addiction–the *Journal of Inebriety.* The *Journal,* edited by Dr. T.D. Crothers during its entire publication life (1876-1914), was filled with essays by addiction medicine specialists and with advertisements promoting various treatment institutions (43, 44). A similar inebriety treatment movement was under way in Europe during the last decades of the 19th century, and the first international meetings of addiction medicine specialists were held during this period (45).

American physicians specializing in addiction began releasing texts on the nature of addiction and their treatment methods in the 1860s: Dr. Albert Day's *Methomania: A Treatise on Alcoholic Poisoning* and Dr. W. Marcet's *On Chronic Alcoholic Intoxication*. The production of such literature virtually exploded in the 1880s and 1890s. Among the most prominent texts either written in America or that exerted a significant influence on the practice of addiction medicine in America during this period were Dr. H.H. Kane's *Drugs That Enslave: The Opium, Morphine, Chloral and Hashish Habits,* Dr. Fred Hubbard's *The Opium Habit and Alcoholism,* Dr. Joseph Parrish's *Alcoholic Inebriety: From a Medical Standpoint with Cases from Clinical Records,* Dr. Asa Meyerlet's *Notes on the Opium Habit,* Dr. T.L. Wright's *Inebriism,* Franklin Clum's *Inebriety: Its Causes, Its Results, Its Remedy,* Dr. T.D. Crothers' *The Disease of Inebriety from Alcohol, Opium and Other Narcotic Drugs,* Dr. Norman Kerr's *Inebriety or Narcomania: Its Etiology, Pathology, Treatment and Jurisprudence,* and Dr. Charles Palmer's *Inebriety: Its Source, Prevention, and Cure* (21).

The central organizing concept of 19th century addiction medicine specialists was that of *inebriety*. Inebriety was viewed as a disease that manifested itself in numerous varieties. These varieties were meticulously detailed by clinical subpopulation and drug choice. Addiction medicine texts were often organized under such headings as *alcoholic inebriety, opium inebriety, cocaine inebriety*, and *ether inebriety*. Inebriety was viewed as a disease that sprang from multiple etiological pathways, unfolded in many diverse patterns, and had a variable course and outcome. Inebriety specialists talked eloquently about the need to individualize treatment and by the 1880s, had begun to recognize and study the problem of post-treatment relapse (46).

The treatment methods of the two physician-directed branches of the inebriety movement (the inebriate asylums and the private addiction cure institutes) were quite different, and the conflicts between these branches reflected allopathic and homeopathic approaches to medicine in this period. The inebriate asylum physicians advocated a sustained (1-3 years), legally enforced course of treatment that consisted of drug-assisted detoxification, collateral medical treatments, and a sustained period

of institutional convalescence. The addiction cure institute physicians boasted medicinal specifics (daily hypodermic injections and liquid tonics) that could "unpoison" the addict's cells, destroy the craving and compulsion to use alcohol, opiates, and cocaine—all in four short weeks—cash in advance. Drug treatments within both branches included such substances as cannabis, cocaine, chloral hydrate, paraldehyde, strychnine, atropine, hyoscin, and apomorphine. While some addiction medicine specialists used cocaine as a tonic during detoxification, most warned of the addictive properties of the drug (21).

Most inebriate asylums and addiction cure institutes treated all drug addictions while others, such as Dr. Jansen Mattison's Brooklyn Home for Habitues (opened in 1891), specialized in the treatment of opiate and cocaine addiction (47). The inebriety literature of this period is filled with debates over whether medically-supervised opiate withdrawal should be abrupt, rapid (over days), or sustained (over weeks and months). One also finds discussions of such contemporary issues as the addictiveness and psychological toxicity of cocaine, problems of drug substitution, and the management of the relapsed patient (45).

Understanding of the potential physiological foundations and consequences of addiction increased during the last two decades of the 19th century. Carl Wernicke's 1881 discovery of a psychosis with polyneuritis that resulted from chronic alcoholism and Sergei Korsakoff's 1887 description of an alcoholism-induced psychosis characterized by confusion, memory impairment, confabulation, hallucinations, and stereotyped and superficial speech both underscored the potential organic basis of alcoholic behavior. There was considerable discussion about the potential hereditary transmission of inebriety, as there is today. Between 1899 and 1903, there were also antibody theories of alcoholism that led to experiments with an alcoholism vaccine called *equizine* (48).

A new addiction-related medical society was founded in 1891. The American Medical Temperance Association (AMTA) was formed in Washington, D.C. at the annual meeting of the American Medical Association. Dr. N.S. Davis of Chicago was its founder and first president. The AMTA published the *Bulletin of the American Medical Temperance Association* under the editorship of Dr. J. H. Kellogg, Director of the Battle Creek Sanatarium. (49).

In summary, the field of addiction medicine experienced professionalization and specialization between 1830 and 1900. There were many addiction medicine pioneers who founded medically-directed treatment institutions, men such as Turner, Parrish, Crothers, Day, and later, Dr. Agnes Sparks, one of the first female physicians specializing in addiction medicine. The practice of addiction medicine shifted from the private physician's practice to the institutional setting. Within this institutional practice, there was a growing understanding of the physiological consequences of chronic alcoholism and an extension of the concept of inebriety to embrace dependence upon opium, morphine, cocaine, chloral hydrate, chloroform, and ether. There was a well-articulated addiction disease concept with elaborate protocol for detoxification and rehabilitation, although there was considerable conflict between allopathic and homeopathic approaches to addiction treatment.

The growing field of addiction medicine was infused with optimism in the early 1890s. Dr. T.D. Crothers proclaimed, "The future looks promising, and it is believed that the public will support inebriate asylums with increasing generosity" (50). There were reasons for Crothers' optimism. There was a well-articulated disease concept of inebriety and two addiction-related medical organizations that embraced a field that had grown from a handful of specialized treatment institutions in 1870 to several hundred by the turn of the century. But forces outside the medical profession were stirring that would drive a wedge between the physician and those addicted to alcohol and other drugs.

Demedicalization and the Collapse of Addiction Treatment (1900-1935)

There was a further profusion of addiction medicine texts in the first decade of the 20th century: J.B. Mattison's *The Mattison Method in Morphinism: A Modern and Human Treatment of the Morphine Disease,* T.D. Crothers' *The Drug Habits and their Treatment,* T.D. Crothers' *Morphinism*, and George Cutten's *The Psychology of Alcoholism.* The proliferation of addiction literature couldn't hide the fact that America's response to alcohol and other drug problems was shifting. Between 1900 and 1920, addiction treatment institutions closed in great numbers in the wake of a weakened infrastructure of the field, rising therapeutic pessimism, economic austerity triggered by unexpected depressions, and a major shift in national policy. The country turned its gaze to state and national prohibition laws as the solution to alcohol and other drug-related problems.

As inebriate homes and asylums and the private addiction cure institutes closed in tandem with the spread of local and state prohibition laws, alcoholics were relegated to other institutions. These included the "foul wards" of large city hospitals, the "back wards" of aging state psychiatric asylums, and the local psychopathic hospital, all of which did everything possible to discourage the admission of alcoholics. Wealthy alcoholics/addicts sought discrete detoxification in a new genre of private hospital or sanitarium established for this purpose. These latter institutions were known as "dip shops" (derived from the term dipsomania), "jitter joints," or "jag-farms" (21). There were also efforts to integrate medicine, religion, and psychology in the treatment of alcoholism, most notably within the Emmanuel Clinics in New England (51). For all but the most affluent, the management of the alcoholic shifted from a strategy of treatment to a strategy of control and punishment via inebriate penal colonies. The large public hospitals also bore much of the responsibility for the medical care of the chronic alcoholic (52).

The shift from viewing the alcoholic as a diseased person in need of help to a person of weak character was reflected in the medical literature of the early twentieth century. Kurtz and Kraepelin coined the term "alcohol addiction" to depict those whose will was "not strong enough to abandon the use of alcohol even if drinking causes them serious economic, social and somatic changes" (34). Addiction medicine organizations struggled in this shifting cultural climate. The American Medical Temperance Association and the American Association for the Study and Cure of Inebriety merged in 1904 to create the American Medical Society for the Study of Alcohol and Other Narcotics. In 1906, the Scientific Temperance Federation was founded by Dr. T.D. Crothers and Frances Stoddard. The Federation published the *Scientific Temperance Journal*. A year later, the *Journal of Inebriety* merged with *The Archives of Physiological Therapy.* This marked the progressive demise of both the *Journal of Inebriety* and its parent organization. The last issue of the *Journal of Inebriety* was published in 1914, and the American Association for the Study and Cure of Inebriety collapsed in the early 1920s following passage of the Volstead Act and the subsequent sharp decline in demand for treatment. Alcohol-related problems decreased dramatically in the early 1920s but rose to pre-prohibition levels by the late 1920s (21). The Eighteenth Amendment to the U.S. Constitution transferred cultural ownership of alcohol problems from physicians to law enforcement authorities. A similar process was underway with drugs other than alcohol, but it took two decades for this shift in approach to fully emerge.

Early 20th century addiction texts by physicians such as George Pettey and Ernest Bishop boldly proclaimed that narcotic addiction was a disease, and Dr. Foster Kennedy declared that morphinism was "a disease, in the majority of cases, initiated, sustained and left uncured by members of the medical profession" (53, 54, 55). Physicians such as Dr. Charles Terry and Dr. Willis Butler had already begun

operationalizing this addiction disease concept by advocating and offering clinic-directed detoxification and maintenance of incurable narcotic addicts (56, 57, 58, 59). The medical treatment of narcotic addicts was dramatically altered by passage of the Harrison Anti-Narcotic Act of 1914. This federal act designated physicians and pharmacists as the gatekeepers for the distribution of opiates and cocaine. While this law was not presented as a prohibition law, a series of Supreme Court interpretations of the Harrison Act (particularly the 1919 *Webb vs. the United States* case) declared that for a physician to maintain an addict on his or her customary dose is not in "good faith" medical practice under the Harrison Act and therefore an indictable offense (19).

There was one brief opportunity to alter the subsequent history of narcotic control policy and the history of addiction. It came in the form of the France Bill, which was introduced in Congress in 1919. This proposed legislation would have provided federal support for physician-directed, community-based treatment of narcotic addicts. The Bill did not have enough support to come to a vote. In spite of this lack of federal leadership, physicians in forty-four communities operated morphine maintenance clinics between 1919 and 1924. These clinics, which were sponsored by local health departments and even local police departments, all eventually closed under threat of federal indictment (19, 21). The Harrison Act, in effect if not intent, transferred responsibility for the care of addicts from physicians to criminal syndicates and the criminal justice system by threatening physicians with loss of license and incarceration if they provided maintenance rather than rapid detoxification of addicts (60).

Physician culpability in the problem of narcotic addiction made it difficult for the American Medical Association (AMA) to oppose this government infringement in medical practice. In 1919, the AMA passed a resolution opposing ambulatory treatment, in effect opposing narcotic maintenance as treatment. There were, however, many physicians who became harsh critics of the Harrison Act and this new era of criminalization. Such criticism was reflected in the new addiction medicine texts that emerged in the 1920s, such as Dr. Ernest Bishop's *The Narcotic Drug Problem* and Dr. E. H. Williams' *Opiate Addiction: Its Handling and Treatment* (61, 62, 63).

The influence of psychiatry on the characterization and treatment of addiction increased in tandem with the decline of a specialized field of addiction medicine. Karl Abraham's 1908 essay, *The Psychological Relations between Sexuality and Alcoholism*, marked the shift from seeing alcoholism as a primary medical disorder to seeing the condition as a symptom of underlying psychiatric disturbance (64). Abraham's essay marked a long series of psychoanalytic writings that viewed alcoholism as a manifestation of latent homosexuality. In the mid-1920s, Public Health Service psychiatrist, Dr. Lawrence Kolb, published a series of articles challenging earlier physiological explanations of narcotic addiction. Kolb portrayed addiction as a product of defects in personality—a characterization that reflected the growing portrayal of addicts as psychopathic and constitutionally inferior (65). The first American Standard Classified Nomenclature of Disease (1933) included the diagnoses of "alcohol addiction," "alcoholism without psychosis", and "drug addiction" and classified these conditions as personality disorders (66).

Few institutional resources existed for the treatment of alcoholism and narcotic addiction during the 1920s and early 1930s, but the growing visibility of these problems began to generate new proposals for their management. The opening of the California Narcotics Hospital at Spadra in 1928 marked the beginning of state support for addiction treatment (67). Physicians working within the federal prison system were writing about the problems posed by a growing population of incarcerated addicts and advocating more specialized treatment of the addict (68).

There were important addiction-related research studies in the 1920s. Drs. Arthur B. Light and Edward G. Torrance

conducted research on opiate addicts at the Philadelphia General Hospital under the auspices of the Philadelphia Committee for Clinical Study of Opium Addiction Research. They demonstrated that withdrawal from opiates is not life threatening and usually not dangerous–a finding that was misused by policy-makers to withhold medical care for addicts (69). In 1928, the Bureau of Social Hygiene published Charles Terry and Mildred Pellens' work, *The Opium Problem* (70). In this important report, Terry and Pellens made a strong argument in favor of addiction maintenance as the most appropriate treatment for addicts who are not able to sustain abstinence. Their views were viciously attacked, and it would only be years later that *The Opium Problem* would be recognized as one of the best treatises on opiate addiction ever written (58).

Medical treatments for narcotic addiction in the first three decades of the 20th century continued to focus on managing the mechanics of narcotic withdrawal. Heroin was briefly used in the detoxification of morphine addicts, and its subsequent emergence as the drug of preference among addicts bred caution in the choice of any narcotic as a withdrawal agent. This fear of exposing patients to other addicting agents led to experimentation with a wide variety of non-narcotic withdrawal procedures. These procedures included various belladonna treatments (scopolamine and hyoscine) that were known to induce hallucinations, peptization treatments (sodium thiocyanate) that could induce long-lasting psychosis, sleep treatments (sodium bromide) that had a 20% mortality rate, injected Narcosan—a lipoid treatment thought to eliminate toxins and stimulate new blood formation but which actually worsened withdrawal, insulin treatments that had no effect on the withdrawal process, and serum and blood therapies in which either previously drawn blood or serum (the latter drawn from induced blisters) was re-injected as a purported aid to detoxification (71, 72, 73).

The first decades of the 20th century were marked by a profound therapeutic pessimism regarding treatment of alcoholism and narcotic addiction. Biological views of addiction fell out of favor and were replaced by psychiatric and criminal models that placed the source of addiction within the addict's character and argued for the control and sequestration of the addict.

The Rebirth of Addiction Treatment (1935-1970)

Following the early twentieth century collapse of systems of care for those addicted to alcohol and other drugs, addiction medicine was revived within the larger context of two movements.

The "modern alcoholism movement" was ignited by the founding of Alcoholics Anonymous (1935), a new scientific approach to alcohol problems in post-Repeal America led by the Research Council on Problems of Alcohol (1937) and the Yale Center of Alcohol Studies (1943), and a national recovery advocacy effort led by the National Committee for Education on Alcoholism (1944). Two goals of this movement were to encourage local hospitals to detoxify alcoholics and to encourage local communities to establish post-hospitalization alcoholism rehabilitation centers (74). This movement spawned new institutional resources for the treatment of alcoholism from the mid-1940s through the 1960s, including "AA wards" in local hospitals, model outpatient alcoholism clinics developed in Connecticut and Georgia, and a model community-based residential model pioneered by three alcoholism programs in Minnesota: Pioneer House (1948), Hazelden (1949) and Willmar State Hospital (1950). Dr. Nelson Bradley, who led the developments at Willmar, later adapted the Minnesota Model for delivery within a community hospital. That adapted model was franchised throughout the United States in the 1980s via Parkside Medical Services and was replicated by innumerable hospital-based treatment programs.

The spread of these models nationally was aided by efforts to legitimize the work of physicians in the treatment of alcoholism. Early milestones in this movement included landmark resolutions on

alcoholism passed by the American Medical Association (1952, 1956, 1967) and the American Hospital Association (1944, 1951, 1957) that paved the way for hospital-based treatment of alcoholism. The former were championed by Dr. Marvin Block, chairman of the AMA's first Committee on Alcoholism. Mid-century alcoholism treatments included nutritional therapies, brief experiments with chemical and electro-convulsive therapies, psychosurgery and new drug therapies, including the use of disulfiram (Antabuse), stimulants, sedatives, tranquilizers and LSD (21).

A mid-twentieth century reform movement advocating medical rather than penal treatment of the opiate addict also helped spawn the rebirth of addiction medicine. This began with the founding of state-sponsored addiction treatment hospitals (e.g., Spadra Hospital in California) and led to the creation of two U.S. Public Health Hospitals within the Bureau of Prisons—one in Lexington, Kentucky (1935), the other in Fort Worth, Texas (1938). Many of the pioneers of modern addiction medicine and addiction research—Drs. Marie Nyswander, Jerry Jaffe, George Vaillant, Patrick Hughes and others--received their initial training at these facilities. The documentation of relapse rates following community re-entry from Lexington and Forth Worth confirmed the need for community-based treatment. Three replicable models of treatment emerged: ex-addict directed therapeutic communities, methadone maintenance pioneered by Drs. Vincent Dole and Marie Nyswander, and outpatient drug free counseling (21).

State and federal funding for alcoholism and addiction treatment slowly increased from the late 1940s through the 1960s and was followed by landmark legislation in the early 1970s that created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA)—the beginning of the federal, state and local community partnership that has been the foundation of modern addiction treatment. Parallel efforts were underway to provide insurance coverage for the treatment of alcoholism and other drug dependencies. The expansion of such insurance coverage in the 1960s and 1970s and the establishment of accreditation standards for addiction treatment programs by the Joint Commission on Accreditation of Hospitals set the stage for the dramatic growth of hospital-based and free-standing, private addiction treatment programs in the 1980s. NIAAA and NIDA also made heavy investments in research that led to dramatic breakthroughs in understanding the neurobiology of addiction that encouraged more medicalized approaches to severe alcohol and other drug problems and an expanding menu of psychopharmacological adjuncts in the treatment of addiction (75).

The growing sophistication of addiction science was aided by other key organizations. The College of Problems of Drug Dependence (CPDD), which dates from the Committee on Problems of Drug Dependence established in 1929, hosts an annual scientific meeting and publishes the journal *Drug & Alcohol Dependence*. The Research Society on Alcoholism (RSA), founded in 1976, also holds an annual scientific conference and publishes the journal *Alcoholism: Clinical and Experimental Research*.

Addiction Medicine Comes of Age (1970-2008)

The re-emergence of addiction medicine as a clinical specialty of medical practice has been significantly advanced by two professional associations: the American Society of Addiction Medicine (ASAM) and the American Academy of Addiction Psychiatry (AAAP).

The American Society of Addiction Medicine can trace its roots to the establishment of the creation of a New York City Medical Committee on Alcoholism in 1951 by the National Council on Alcoholism, the 1954 founding the New York State Medical Society on Alcoholism under the leadership of Dr. Ruth Fox, and the movement of this group in 1967 to establish itself as a national organization—the American Medical Society on Alcoholism

(AMSA). AMSA was later evolved into the American Medical Society on Alcoholism and Other Drug Dependencies and then into the American Society of Addiction Medicine (ASAM). ASAM's achievements include:

- advocating the American Medical Association's addition of addiction medicine to its list of designated specialties (achieved in June 1990),
- offering a certification and recertification process for addiction medicine specialists based on the early work of the California Society of Addiction Medicine,
- hosting its annual addiction medicine conference,
- publishing its widely utilized patient placement criteria,
- development of the *Principles of Addiction Medicine*, and
- publishing first the *Journal of Addictive Diseases* and presently the *Journal of Addiction Medicine*.

ASAM has been very influential in establishing addiction medicine as a legitimate medical specialty. There are currently more than 4,000 ASAM certified physicians.

The American Academy of Addiction Psychiatry (formerly the American Academy of Psychiatrists in Alcoholism and the Addictions) was established in 1985 with the goal of elevating the quality of clinical practice in addiction psychiatry. The AAAP's contributions include successfully advocating that the American Board of Psychiatry and Neurology grant addiction medicine a subspecialty status (1991), administering an addiction psychiatry certification and recertification process, hosting an annual conference on addiction psychiatry, publishing the *American Journal on Addictions*, and promoting fellowships in addiction psychiatry (76).

Several additional initiatives have advanced addiction-related medical education. NIAAA and NIDA created the Career Teacher Program (1971-1981) that develop addiction-related curricula for the training of physicians in 59 U.S. medical schools. In 1976, Career Teachers and others involved in addiction-related medical education and research established the Association of Medical Education and Research in Substance Abuse (AMERSA). AMERSA draws its members primarily from American medical school faculty, hosts an annual meeting and publishes the journal *Substance Abuse*. In 1980, the Consortium for Medical Fellowships in Alcoholism and Drug Abuse was established to promote addiction-focused research and teaching specialists.

Today (2008), there are more than 14,400 physicians working within a network of 13,200 specialized addiction treatment programs in the United States who help care for the more than 1.9 million individuals and families admitted for treatment each year (77). As this history has reviewed, addiction medicine rose in the United States in the mid-nineteenth century, collapsed in the opening decades of the twentieth century, but re-emerged and became increasingly professionalized in the late twentieth and early twenty-first centuries.

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Citation: McKay, J.R., Carise, D., Dennis, M.L., Dupont, R., Humphreys, K., Kemp, J., Reynolds, D. White, W., Armstrong, R., Chalk, M., Haberle, B., McLellan, T., O'Connor, G., Pakull, B. and Schwartzlose, J. (2009). Extending the benefits of addiction treatment: Practical strategies for continuing care and recovery, *Journal of Substance Abuse Treatment*, 36, 127-130. Posted at **www.williamwhitepapers.com**

Introduction to a series of special papers based on the Second Betty Ford Institute Consensus Conference: Extending the Benefits of Addiction Treatment: Practical Strategies for Continuing Care and Recovery. October 3-4, 2008, Rancho Mirage, CA.



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Citation: White, W. (2009). A commentary on "consumer": Language, stigma and recovery representation. Posted at **www.williamwhitepapers.com**

A Commentary on "Consumer"
Language, Stigma and Recovery Representation.

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The difference between the right word and the almost right word is the difference between lightning and the lightning bug.—Mark Twain

At every word a reputation dies.—Alexander Pope

By our silence, we let others define us.—Susan Rook (Missouri Recovery Network campaign slogan)

Addiction treatment organizations and a variety of policy-making, planning, and funding authorities are changing their historical focus on acute biopsychosocial stabilization to a broader vision of sustained long-term recovery for individuals and families. This shift can be seen in widespread discussions and practices that embrace "recovery management" and "recovery-oriented systems of care." This change in organizing concepts and service practices will not be possible without the meaningful involvement of individuals and families in or seeking recovery in the planning and decision-making processes.

The word "consumer" is cropping up more frequently, with references to "our consumers," "consumer representation," "consumer councils," and "consumer-based" or "consumer-directed" services. This latest term joins a long list of terms—patients, clients, service users/recipients/participants, alumni—that have described people needing, receiving, or completing addiction treatment and recovery support services.

Historically, language applied to and chosen by historically disenfranchised groups evolves over time. People who were recovering from severe mental illness began their own recovery revolution in the 1970s and 1980s and chose to self-designate themselves as "consumers" and "survivors" as a less stigmatizing alternative to "mental patient." The surge in "consumer" language was a positive development within the history of the mental health recovery advocacy movement—one that at the time was experienced as personally empowering. It is likely that this language will continue to evolve as the mental health recovery advocacy movement continues to evolve.

With the growing integration of addiction treatment and mental health treatment services, the introduction of new medications for the treatment of addiction, and expanded efforts to include coverage for addiction treatment and recovery support services as part of comprehensive health care reform, the use of the word "consumer" is gaining prominence within the addiction treatment and recovery support communities. This brief essay describes why this "consumer" terminology is counterproductive and suggests other ways to describe the critical role that people seeking or in long-term recovery, their families, and friends play in the design, delivery, and evaluation of addiction treatment and recovery support services.

Rejecting the "Consumer" Designation

There are nine reasons to reject the spread of "consumer" language when talking about addiction treatment and recovery support services.

1. The term "consumer" is ill-defined and as such, may create further misunderstanding by the general public and policymakers about people experiencing addiction or who are in long-term addiction recovery. There is no generally understood meaning of what exactly is being consumed, and members of the public may well think the term refers to people who continue to consume excessive amounts of alcohol and/or drugs.

"The 'consumer' language suggests that the person in treatment is a social 'taker,' that they suck up community resources and give nothing in return—a parasitic relationship to others."[1]

People in active addiction are often involved in a parasitic process of using (in the manipulative sense) family, friends, and community resources to sustain their alcohol and drug use. "Consumer" is a more apt description of someone in active addiction than of a person in long-term recovery. Furthermore, the most cursory search of "consumer" on the internet reveals meanings that include a person who drinks alcohol to excess (See http://www.thefreedictionary.com/consumer). A person in recovery is more aptly described as a person who ceases being a consumer.

2. The term "consumer" fails to provide an alternative identity for persons attempting to disengage from alcohol/drug-saturated lifestyles and subcultures. Addiction treatment can be a transitional bridge from a culture of addiction to a culture of recovery or a revolving door within a person's active addiction career. The "consumer" identity tends to reinforce the latter; focusing on the repeated "consumption" of services as well as the "consumption" of alcohol and other drugs. "Person in recovery," in contrast, builds a new identity for an individual moving forward to a new life. "Consumer" defines a person in terms of a part of the self while ignoring the whole. Participating in addiction treatment is an activity, not who a person is.

The term "consumer" had value at a particular point in time for persons recovering from mental illness. New language that had value within a particular historical context can become old language and stand as an obstacle to progress as contexts change. We need a different term to describe people seeking and in long-term recovery from addiction and people who participate in addiction treatment as part of that long-term journey. Does that mean that any alternative language we embrace today may need to be given up in the future? We need to be open to that possibility.

3. The term "consumer" ties an individual's identity to a service delivery system, be it a treatment provider or a physician prescribing medications, and can be paternalistic and disempowering. There are words other than "consumer" that

[1] Jason Schwartz, Personal Communication, June 12, 2009.

can be used to describe a relationship between a person receiving professional care and the caregiver. For example, in the HIV/AIDS community, people who receive medications from a physician often describe themselves as patients when talking about their relationship with their doctor. Similarly, many people using medications in their recovery describe themselves as a "person in long-term recovery using medication," as a "patient" when describing their relationship with their physician, or as a "client" when describing their relationship with a clinic.

The problem is that when "consumer" is juxtaposed against "professional" or "provider," as it often is, "consumer" conveys a person of less value and authority and implies that the individual has value only to the extent to which they consume professional services or products. This juxtaposition further creates the delusion that the "provider" is whole/well and the consumer is "broken/sick." Both are dehumanized by this process, with one denied of weakness and the other denied of strength. The "consumer" designation reflects a hierarchical relational model that rests on twin propositions: 1) "the professional knows best" and 2) the role of the "patient/consumer is to listen and comply."

"Consumer" also defines a person in terms of his or her problems. It relegates the person to being one, albeit critical, component of a system of care, rather than as the driver of that care and the person around whom all care is to be organized so that the person is able to get well. There is nothing in the term that conveys autonomy (or even healthy interdependence), competence, responsibility, or describes the assets that the person brings to others and the community. "Consumer" does not convey the status of, or hope for, recovery and seems alien when linked to words like liberation, journey, transformation, Higher Power, redemption, spirituality, and service, to name just a few of the words and concepts that are associated with recovery. If we need a name, then let's use words that convey wholeness and wellness, words like "citizen," "person in long-term recovery," or "person seeking recovery."

4. Using the term "consumer" to convey the involvement of people in recovery and their families in advisement or decision-making roles narrowly restricts the pool of people considered for such participation. For example, the term "consumer" would not include individuals/families in need of recovery who have never sought professional help, individuals who did not complete and may have had a "bad" experience in treatment, and individuals and families who achieve long-term recovery without the aid of professional treatment. Referring to such people as "consumers" (of addiction treatment services) is simply inaccurate.

Individuals in treatment constitute only a small, unrepresentative sample of those who have experienced and/or have resolved alcohol and other drug problems. Too often, "consumer" represents an even smaller sample: individuals who have successfully "graduated" from treatment and, out of deep gratitude for their personal recovery, can offer testimony to a particular program's effectiveness.

"Consumer" councils that guide federal, state, or local recovery-focused initiatives must include a wide range of voices as part of the advisory process. The term "consumer" does not adequately describe the scope of needed representative. Voices must be heard who represent diverse levels of problem severity/complexity, recovery capital, and pathways and styles of long-term recovery. The homogenous designation "consumer" ignores the distinct cultural histories and the enormous diversity of needs and circumstances people bring to the experiences of recovery initiation and recovery maintenance.

5. The "consumer" designation inadvertently serves as a mechanism of "outing." To routinely introduce someone as a "consumer representative" or a member of "our consumer council" discloses the person's status as a former treatment

recipient or person in recovery and places the institution rather than the individual in control of when, where, to whom, and under what circumstances his or her recovery status is disclosed. For professional treatment institutions, such communications often constitute an inadvertent breach of ethics (confidentiality) and etiquette (respect, privacy, discretion). For the people serving in this role, the "consumer representative" designation diminishes and restricts how they are perceived by others and how they perceive themselves.

6. Terms such as "consumer," "client," "patient," and "previously incarcerated person (PIP)" are inappropriate in the context of peer-based recovery support services. These terms imply a hierarchical service relationship model that is incongruent with peer-based recovery support. For example, when a recovery coach commented to a treatment professional that they did not refer to the people they served as "clients" or "consumers," the professional asked, "Well then, what do you call them?" The simple response was, "Collectively, we call them people; individually, we call them by their names." This response indicates a different relationship—not only one of mutual respect, but one that embraces the reciprocity that is at the core of peer recovery support relationships. The term "consumer" reflects the role dichotomy of helper (a producer of services) and helpee (a user of services); in the world of peer recovery support services, each person both gives and receives.

As more people return to communities from prison in search of sustained recovery, new acronyms are popping up. Unfortunately, these names and acronyms continue to objectify and turn individuals into an aggregate object, e.g., previously incarcerated persons (PIPs) and formerly incarcerated persons (FIPs). Such names and acronyms have no place in the world of addiction treatment and recovery support services.

7. Embracing this term in the addiction treatment and addiction recovery support arenas may amplify stigma by pairing the stigma already attached to addiction with the stigma attached to mental illness. Given the dominance of the term "consumer" within the mental health field over the past two decades and the existing Consumer Advisory Councils for people with mental illness in each state, "consumer" has become a code word for mental illness. Joint use of "consumer" by the two fields may compound social stigma by inadvertently signaling that all "consumers" have histories of both mental illness and alcohol/drug addiction.

The use of "consumer," because of its association with the mental health field, may also reinforce the view that addiction is a symptom of mental illness and not a primary disorder. It is critical that people with co-occurring addiction and mental illness receive the specialized and integrated services that they need to achieve long-term recovery. However, it is imperative that addiction is recognized and treated as a primary disorder.

8. The term "consumer" used in the context of addiction treatment mistakenly conveys the image of a seller-buyer relationship, with an informed customer having substantial autonomy, power, and choice and rights of redress if the product or service is faulty. This is not an accurate depiction of most persons entering addiction treatment in the United States today. The growing percentages of people entering treatment via external coercion, the substantial power differential between addiction professionals and their "patients," the limited choices available to those forced into treatment, the lack of knowledge about those choices, the absence of lobbyists and advocacy organizations representing individuals and families in addiction treatment, and the lack of any significant mechanisms of redress for ineffective or harmful treatment are all obscured by referring to those entering

addiction treatment as "consumers."[2] The term "consumer" is used in few other contexts in which choice and redress are so limited.

9. <u>The term "consumer" has a commercial/marketing/sales connotation that overemphasizes the business aspects of addiction treatment and is particularly ill-suited for people involved in volunteer, peer-based recovery support services provided by recovery community organizations</u>. The term "consumer," perhaps not unexpectedly, came into prominence in the roaring "greed is good" days of the 1980s when addiction treatment organizations were told they needed to shift their identity from that of a service program to one of a business.

"Americans are urged through ubiquitous advertising to construct their identities through consumerism; they are expected to be positive economic actors through consumption."[3]

The commodification of addiction treatment and its accompanying language has been a corrupting force within the treatment field and set the stage for calls to de-commercialize and re-humanize the service relationship. The "consumer" designation is incongruent with the sustained person-professional and peer-peer partnerships being advocated as the ideal models of long-term recovery support. The commercial/commodity aspects of the term "consumer" are also part of a value system that attributes personal value to the possession/consumption of goods and services. It conflicts with a recovery value system that defines personal identity in terms of humility, restitution (paying rather than incurring debt), service (an emphasis on giving rather than owning), and simplicity.

Final Reflection

The addictions field could learn much from the larger disabilities movement of recent decades. Some of the central ideas of this movement include the following:

- Language matters. It is far more than superficial concerns about political correctness.
- Language is imbedded with values and judgments of a culture; cultural change involves a transformation in language.
- The labels applied to individuals affect how they are perceived by others and how they perceive themselves.
- Language is a vehicle of social control and social isolation. Stigma and discrimination are couched in a language that reinforces stereotypes and elicits fear.
- Recovery and community integration require claiming one's own language.
- Language that focuses on the person is more respectful and less stigmatizing than language that defines a person in terms of an illness.

It will be interesting to see how the language of addiction treatment and recovery evolves in tandem with the dramatic changes that are unfolding within these worlds. I hope we will not be talking much longer about "consumers" or "consumer councils" but will instead be talking about people in recovery and recovery (or citizen) advisory councils. I also

[2] Referrals from the criminal justice system increased from 38% of total referrals in 1990 to 59% of referrals in 2004. During this same time period, referrals from welfare and child protection systems increased from 8% to 16%. McLellan, A.T. (2006). *Addiction is changing: How changes in systems and customers may affect the Betty Ford Institute*. Presentation to Betty Ford Institute Executive Council, February, Rancho Mirage, CA.

[3] Acker, C.J. (1993). Stigma or legitimation? A historical examination of the social potentials of addiction disease models. *Journal of Psychoactive Drugs, 25*(3), 193-205, quotation from page 203.

hope that the paternalistic "our patients," "our clients," and "those we treat" will evolve in the near future to "people we serve."

People First Language puts the person before the disability, and describes what a person has, not who a person is…People First Language was created by individuals who said, "We are not our disabilities." It's not "political correctness," but good manners and respect. –Kathie Snow

Words can elicit fear, contempt, anger, or pity, but they can also elicit understanding, compassion, and respect. Individuals and families in recovery are awakening culturally and politically. As they do, they will forge their own language to collectively convey their "experience, strength, and hope." They will challenge the traditional language that has been used culturally and professionally to depict alcohol and other drug problems and their resolution. Most importantly, they will claim entitlement to select the words used to refer to those who have experienced addiction and recovery.

Acknowledgements: I would like to thank the following individuals for their thoughtful response and suggestions on an early draft of this paper: Ben Bass, Mike Flaherty, Joan King, Roland Lamb, Joe Powell, Jason Schwartz and Phil Valentine. Special thanks to Pat Taylor of Faces and Voices of Recovery for her particularly thoughtful review and suggestions.



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Citation: White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58. Posted at **www.williamwhitepapers.com**

The Mobilization of Community Resources to Support Long-term Addiction Recovery

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Abstract

Models of addiction treatment that view the sources and solutions to severe alcohol and other drug (AOD) problems as rooted within the vulnerability and resiliency of each individual stand in marked contrast to models that focus on the ecology of AOD problem development and resolution via complex interactions between individuals, families, and communities. An integration of the latter model into mainstream addiction treatment would necessitate a reconstruction of the treatment-community relationship and new approaches to community resource development and mobilization. Such an integration would redefine core addiction treatment services and to whom, by whom, when, where, and for how long such services are delivered. This article draws on historical and contemporary events in the history of addiction treatment and recovery in the United States to illuminate the relationship between recovery and community. Principles and strategies are identified that could guide the development and mobilization of community resources to support the long-term recovery of individuals and families.

Key Words: addiction recovery, recovery management, recovery community, continuing care, outreach, community organization

We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.
-Sandra Bloom (Creating Sanctuary, p117)

1. Introduction

The development and resolution of severe alcohol and other drug (AOD) problems involves intrapersonal, interpersonal, and broader systems-level processes, but the dominant

modalities and levels of care of addiction treatment are distinctly intrapersonal in their orientation. Mainstream services seek to modify the physiology, thoughts, feelings, and behaviors of individual service consumers with little effort extended to "treat" the larger physical and relational worlds in which individual recovery efforts succeed or fail.

Several influences are converging to push this intrapersonal orientation to a more relational and systems-focused perspective. There is growing recognition that recovery initiation in institutional settings does not assure sustained recovery maintenance in natural community environments (Weisner, Matzger, & Kaskutas, 2003; Westermeyer, 1989). Addiction recovery mutual aid societies are growing in size and geographical dispersion and diversifying in their philosophical orientations (Humphreys, 2004; White, 2004), and there are historically significant recovery community building activities, including the spread of recovery homes, recovery schools, recovery industries, recovery ministries/churches, and new recovery community organizations and service roles (Jason, Davis, Ferrari et al., 2001; Valentine, White, & Taylor, 2007; White & Finch, 2006; White, 2006b). A new grassroots addiction recovery advocacy movement is: 1) calling for a reconnection of addiction treatment to the larger and more enduring process of addiction recovery, 2) advocating a renewal of the relationship between addiction treatment institutions and the grassroots communities out of which they were birthed, and 3) extolling the power of community in the long-term recovery process (Else, 1999; Morgan, 1995; White, 2006a, 2007b).

Scientific evidence is also confirming the limitations of current intrapersonal, acute-care models of addiction treatment as measured by such performance indicators as attraction, access, engagement, retention, post-treatment relapse rates, and treatment re-admission rates (White, 2008). Scientists and clinical leaders are advocating that addiction treatment shift from a model of acute bio-psychosocial stabilization to a model of sustained recovery management that would emulate the treatment of other chronic health conditions (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000; O'Brien & McLellan, 1996; White, Boyle, & Loveland, 2002). Interest is also growing in public health and harm reduction strategies that integrate environmental and clinical strategies of AOD problem resolution (Kellog, 2003; Tatarsky, 2003).

Recovery is emerging as an organizing paradigm for behavioral health care policy (DHHS, 2003; IOM, 2006; White, 2005), addiction and mental health services integration (Davidson & White, 2007; Gagne, White, & Anthony, 2007), federal service program initiatives (e.g., CSAT's Recovery Community Support Program and Access to Recovery program; Clark, 2007), and state and local behavioral health care system transformation efforts (Evans, 2007; Kirk, 2007). This has in turn sparked interest in defining recovery (Betty Ford Institute Consensus Panel, 2007) and in mapping the pathways, styles, and stages of long-term recovery (White & Kurtz, 2006b). Collectively, there is growing focus on the *ecology of addiction recovery*--how the relationships between individuals and their physical, social, and cultural environments promote or inhibit the long-term resolution of severe AOD problems.

Families, kinship and social networks, and communities can be considered in need of treatment and recovery when the health and performance of its members and the system as a whole have been severely impaired by alcohol- and other drug-related problems. In this view, parallel processes exist between the wounding and healing of the individual, the family, and the community. Much of what is known about the recovery of individuals (De Leon, 1996; White, 1996) is paralleled in the recovery of families (Brown & Lewis, 1999), kinship and social networks (Galanter, Dermatis, Keller, & Trujillo, 2002), and whole communities (Williams & Laird, 1993). Table One depicts such parallel processes.

Table One: Individual, Family, and Community Recovery

Parallel Processes in Personal, Family and Community Recovery
1. Honest acknowledgement of AOD problems and their severity. 2. Admission that past problem solving efforts have failed. 3. Visible expression of commitment to change. 4. Inventory of assets and vulnerabilities. 5. Development of a recovery action plan. 6. Recovery initiation, resource mobilization, and recovery stabilization. 7. Management of continuing self-defeating patterns of thinking, feeling, acting, and interacting. 8. Character and identity (story) reconstruction (who we were, what happened, who we are now and are becoming). 9. Reconciliation and reconstruction of key relationships. 10. Recovery maintenance rituals (e.g., centering rituals, sober fellowship, acts of self-care, acts of citizenship and service).

Individuals, families, kinship networks, and communities, through their interactions with one another, can perform both wounding and healing functions (Falkin & Straus, 2003; Schmitt, 2003). The purpose of this current paper is to set forth a set of historically grounded principles and strategies to guide the development and mobilization of community resources to facilitate recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families.

2. Historical Perspectives on Recovery and Community

There are informative periods in the history of addiction treatment and recovery that illustrate the power of community in the recovery process and the link between community revitalization and the recovery of individuals and families.

2.1 *Native American recovery movements*

Coyhis and White (2006) have catalogued more than 250 years of abstinence-based religious and cultural revitalization movements among Native American tribes. For historically disempowered and besieged groups, the processes of personal/family recovery are inseparable from larger processes of religious and cultural revitalization. A single individual can serve as a catalyst for community healing, and the recovery of a family or a community can widen the pathway of entry into recovery for individuals—a process vividly portrayed in the modern history of the Shuswap tribal community in Alkali Lake, British Columbia (Coyhis & White, 2006; Taylor, 1987).

The contemporary Native American Wellbriety Movement, a grassroots recovery advocacy movement started in 1999 to promote addiction recovery and wellness in American Indian communities, uses the metaphor of a *healing forest* to portray this connection between individual, family, and community. The acute, intrapersonal model of addiction treatment is portrayed as digging up a sick and dying tree, transplanting and nourishing it back to health, and then replanting it in the soil from which it came. This Wellbriety metaphor calls for moving beyond the treatment of sick trees to the creation of a healing forest in which the health of individual trees, the soil, and the environment are simultaneously elevated (Coyhis & White, 2006).

2.2 *The Washingtonians, the Keeley Leagues, Alcoholics Anonymous, and Synanon*

There is a long and rich history of addiction recovery mutual aid organizations in the United States (White, 2001). Three such organizations reveal important lessons about the relationship between community and recovery (All accounts are from White, 1998). The Washingtonians, founded in 1840 as a recovery mutual aid fellowship, grew to more than 400,000 members within 48 months and then rapidly declined. One of the sources of their demise was their engulfment by the larger community (e.g., abandonment of their closed meeting structure) that diminished the mutual identification between their alcoholic members. The Washingtonian saga suggests that when recovery communities become too connected to the outside community, they are vulnerable to identity diffusion, colonization, and collapse.

The Keeley Leagues were organized as a patient support group within the Keeley Institutes—a private addiction cure institute founded in 1879 that was franchised in more than 120 locations in America and Europe. The Keeley Leagues flourished (more than 30,000 members in 370 chapters) until the founder attempted to convert the leagues from its function of recovery support to "a great advertising medium" (White, 1998, p. 57). The Keeley League saga confirms that indigenous recovery mutual aid groups can be hijacked to serve the financial interests of other community institutions and that organizational collapse is often the product of such colonization. Great care must be taken in forging the relationship between professional organizations and indigenous recovery support institutions.

Alcoholics Anonymous (AA), founded in 1935, is the largest, most geographically accessible, and most widely adapted recovery mutual aid structure in the world (Kurtz, 1979). Early in its history, AA worked out its relationship to community via formulation of its Twelve Steps (emphasizing resources and relationships beyond the self; amends to others, and service to others) and Twelve Traditions (emphasizing singularity of purpose, organizational autonomy, financial self-support, a public relations policy of attraction rather than promotion, and anonymity at the level of press) (Alcoholics Anonymous, 1981). One of AA's unique contributions is its ability to create a closed recovery community without isolating its members from full participation in the larger community.

Synanon was founded by Charles Dederich in 1958 as the first ex-addict-directed therapeutic community (TC) in the United States. The original vision was a three-phase experience: 1) total enmeshment within the life of the TC, 2) living in the TC while working or going to school in the community, and 3) living and working outside while returning to the TC for support. When relapses occurred during community re-entry, Synanon progressively lengthened phase one and eventually abandoned phases two and three. At that point, Synanon became a closed community and began its slow path to organizational self-destruction (Janzen, 2001).

The Synanon story suggests that when communities of recovery become too disconnected from the larger community, they become vulnerable to the vagaries of charismatic leadership, cult-like isolation, ideological extremism, internal schisms, breaches in ethical and legal conduct, and eventual implosion. The story of Synanon also reflects how institutions whose stated mission is to rehabilitate and return recovering addicts to their communities often end up further isolating recovering people from the natural communities within which successful long-term recovery must be firmly nested. Participation in treatment and recovery support institutions can lead to isolation from the community or serve as a bridge to greater community participation (Kurtz & Fisher, 2003).

2.3 The prohibitionist vision

The prohibition movements of the late nineteenth and twentieth centuries grew in a climate of growing therapeutic pessimism about the prospects of long-term recovery. Those with alcohol and other drug problems became demonized and cast as a threat to the health and future of American civilization. The new policy called for letting the existing alcoholics and addicts die

off while preventing a new generation of AOD problems via the prohibition of the sale of alcohol and the aggressive control of opium, morphine, and cocaine (Musto, 1973).

This shift in cultural climate and its resulting policies led to the collapse of America's inebriate homes, inebriate asylums, and addiction cure institutes; the passage of mandatory sterilization laws that targeted alcoholics and addicts as well as the mentally ill and developmentally disabled; and the sequestration of alcoholics and addicts in inebriate penal colonies and the "back wards" of aging state psychiatric asylums (White, 1998). When community members become frightened, those with severe AOD problems are vulnerable for scapegoating and extrusion from the community, particularly when these fears are heightened by gender, class, racial, and intergenerational conflict. This principle illustrates a potentially more ominous influence of community—the power of community to do harm to individuals and families affected by AOD problems.

2.4 Early industrial alcoholism programs

In the mid-1940s, a number of companies began utilizing employees who had found sobriety in A.A. to work with other employees experiencing alcohol-related problems. These experiments evolved into early occupational alcoholism programs, which later gave rise to "broadbrush" employee assistance programs (EAPs). The historical evolution of EAPs is instructive. These programs progressively shifted their focus from alcohol problems to other problems, to organizational wellness, and then to cost benefit management (Roman, 1981). Through this process, alcohol and drug dependence shifted from a health problem (placement of the EAP in the medical department) to a discipline and cost problem (placement of the EAP in the personnel department). EAPs further shifted from face-to-face, onsite services delivered by a workplace peer to telephone-based, offsite services delivered by a service professional who had no background working in the industry, no background of personal recovery, nor any pre-existing relationship with the employee or the employer (White, 1999).

The early history of occupational alcoholism programs was an exercise in recovery community-building; the modern history of employee assistance has been marked by a transition from peer-based assistance within the work setting to professionalized services delivered by individuals outside of the workplace and often outside of the local community. The recent growth in labor assistance programs is, in part, an effort to rebuild those indigenous recovery communities within the workplace (White, 1999; Bacharach, Bamberger, & Sonnenstuhl, 1996). Indigenous, non-professionalized recovery support resources emerging out of the life of an institution or community are at risk of being replaced by, or evolving into, services that, as they are professionalized and commercialized, distance themselves physically and culturally from the natural environments of those they serve.

2.5 The OEO/Iowa community development model

Today, addiction treatment is delivered as an acute care model of professional intervention that involves a series of encapsulated service activities, i.e., screening, assessment, diagnosis, service planning, service delivery, discharge, brief aftercare, and termination of the service relationship. This medicalized approach to AOD problems achieved dominance, but there was a competing model—a road not taken. The alternative model was piloted in several states in the 1960s through the alcoholism programs of the Office of Economic Opportunity (OEO). The OEO model focused on building capacity to address alcohol problems not within a treatment center but within the larger community (White, 1998). These early community-focused alcoholism programs sought to reduce the forces in the community that nurtured the development of alcohol and other drug problems and to create physical and cultural space within the community where recovery could flourish. The key role within this model was the Community Alcoholism Agent (CAA).

The CAA functioned as an outreacher, motivator, advisor, empathic friend, confidant, and "follow-upper" providing a long-term continuum of emotional support and common sense advice, all tailored to the individual case. As a catalyst for the larger community process, he is an educator, mobilizer, coordinator and motivator for anyone and everyone he can get involved in the individual's recovery process….To maximize community involvement, the catalyst does nothing for the alcoholic he can get someone else in the community to do. He acts as a "shoehorn" helping the alcoholic fit himself back into community life through job, family, church, AA, etc., getting as many other people involved in the alcoholic's recovery as possible (Mulford, 1978, p. 6-7).

The healing agent in this model was the community, not the professional clinician. Those who championed the community alcoholism agent model charged that the alcoholism field "sold out" in its search for state and federal funds: "To the extent that the centers turned to face the State Capital, they turned their backs on the alcoholics and the communities they had been serving" (Mulford, 1978, p.11).

The medical and community development models are not mutually exclusive, but this history suggests that, in its search for professional status, an emerging field can shift its emphasis from community mobilization and social and political action to the mastery of clinical technique—a shift not unique to the addiction treatment field (Lubove, 1965; Specht & Courtney, 1994). Interestingly, the community alcoholism agent model bears a striking similarity to the subsequent development of "social model programs" and community guides." The social model, as pioneered in California, is an abstinence-based approach to alcoholism recovery that is distinguished by self-governed, homelike living environments; voluntary, peer-based experiential learning (in contrast to professional instruction/intervention); and deep enmeshment in local recovery communities (Borkman, Kaskutas, Room et al., 1998). Community guides are non-professional peers who help lead marginalized individuals and families back into healthy, supportive, and contributing relationships within their local communities (McKnight, 1995; Ungar, Manuel, Mealey et al., 2004).

2.6 The Recovery Community Support Program

In 1998, the Center for Substance Abuse Treatment created the Recovery Community Support Program (RCSP). The RCSP provided seed money for grassroots recovery community organizations to launch anti-stigma campaigns, recovery education programs for professionals and the public, host recovery celebration events, and advocate for pro-recovery social policies and programs. The vision was to mobilize recovering people and their families and allies into a positive force in communities across the country, and for the next three years, RCSP grantees did exactly that in many communities. RCSP grantees became important building blocks in the rise of the earlier noted new recovery advocacy movement in the United States (White, 2007b).

In 2002, a politically-influenced policy shift abruptly ended the advocacy activities allowed under the RCSP, resulting in a shift in focus from advocacy (which was then banned) to peer-based recovery support services. Almost overnight, RCSP grantees shifted from community organizers and political advocates to recovery support specialists. With the stroke of a pen, a model of recovery community development was transformed into a service mechanism within the acute care model of addiction treatment.

Seen as a whole, the above historical vignettes suggest the power of community to harm and to heal, the role of community in long-term recovery, and the propensity for grassroots models of community development to give way to professional models of clinical intervention. In the remaining discussions, we will explore how this healing power of community could be recaptured to enhance the potency of current intervention models.

3. Treatment, Recovery, Community: Guiding Principles

The role of community in addiction recovery rests on several basic principles.

3.1 AOD problems: sources and solutions

Individuals with severe AOD problems can be viewed as victims of their own vulnerabilities or as symptoms of system dysfunction—by-products of a breakdown in the relationship between the individual, the family, and the community. Such a breakdown can unfold intergenerationally with terrifying predictability, particularly when imbedded within historical trauma and its legacies (Brave Heart, 2003). While neurobiological breakthroughs in the understanding of addiction may quiet the morbid physical appetite of addiction, infatuation with new pharmacological adjuncts have the potential of diverting attention from the broader social processes within which both addiction and recovery flourish.

3.2 Cultures of addiction and recovery

The resolution of severe alcohol and other drug problems is mediated by processes of social and cultural support (Brady, 1995; Laudet, Morgen, & White, 2006; Longabaugh, Beattie, Noel et al., 1993; Spicer, 2001). Both general and abstinence-specific social support influence recovery outcomes, but abstinence-specific support is most critical to long-term recovery (Beattie & Longabaugh, 1999; Groh, Jason, Davis et al., 2007). The risk of relapse following treatment rises in relationship to the density of heavy drinkers in one's post-treatment social network and declines in tandem with social network support for abstinence (Bond, Kaskutas, & Weisner, 2003; Dennis, Foss & Scott, 2007; Mohr, Averna, Kenny, & Del Boca, 2001; Weisner, Matzger, & Kaskutas, 2003). Social support is one of the primary mechanisms of change within recovery mutual aid societies and may be particularly effective in enhancing recovery for individuals imbedded in heavy drinking social networks (Humphreys, Mankowski, Moos, & Finney, 1999; Humphreys & Noke, 1997; Project MATCH Research Group, 1998; Bond, Kaskutas, & Weisner, 2003). The presence or absence of family and peer support for abstinence is a particularly powerful influence on the recovery outcomes of adolescents treated for a substance use disorder (Godley & Godley, in press).

Many persons with severe and prolonged AOD problems migrate toward heavy AOD using cultures as these problems intensify (Buchanon & Latkin, 2008). Such cultures have been extensively described in the early ethnographic literature on addiction (Agar, 1973; Bahr, 1973; Spradley, 1970; Waldorf, 1973). Elaborate cultures also surround the recovery experience for many individuals. The transition from addiction to recovery is often a journey from one culture to another, each with its own distinct trappings (e.g., language, values, symbols, institutions, roles, relationships, and rituals of daily living; White, 1996). Those with the most enmeshed styles of involvement in a culture of addiction may require an equally enmeshed style of involvement in a culture of recovery to successfully avoid relapse and re-addiction. Individuals deeply enmeshed in drug cultures may also need a guide knowledgeable of both cultures to facilitate their disengagement from one world and entrance into the other. Communities vary widely in the degree of development of local cultures of recovery and the availability of such guides. These recovery cultures and cultural guides constitute an invaluable form of *community recovery capital* (White & Cloud, in press).

3.3 Recovery capital

Recovery capital is the quantity and quality of internal and external assets that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Laudet & White, 2008). Such capital exists in varying degrees for individuals, families, and communities and varies dynamically over time within these units. Individuals with low to

moderate AOD problem severity and moderate to high recovery capital often resolve AOD problems on their own through non-professional recovery supports within their family or community or through brief professional intervention. This style of problem resolution is well documented in the early research on *spontaneous remission* and *natural recovery* (Biernacki, 1986; Tuchfeld, 1981; Bischof, Rumpf, Hapke et al., 2003; Rumpf, Bischof, Hapke et al., 2002). Individuals with high AOD problem severity and complexity (e.g., co-occurring disorders/problems) and low recovery capital consume an inordinate quantity of treatment resources as they are recycled repeatedly through multiple episodes of acute biopsychosocial stabilization (White, 2008).

3.4 Recovery is a stage-dependent process; treatment is not recovery.

Stages through which severe AOD problems are resolved can be broadly defined as 1) destabilization of addiction, 2) recovery initiation and stabilization, and 3) recovery maintenance (Biernacki, 1986; Brown, 1985; De Leon, 1996; Frykholm, 1985; Klingemann, 1991; Prochaska, DiClimente, & Norcross, 1992; Shaffer & Jones, 1989; Waldorf, 1983; Waldorf, Reinarman, & Murphy, 1991). While stages one and two can occur in an artificial environment (e.g., via incarceration or hospitalization), stage three can only be fully achieved within a natural environment in the community. Brief episodes of crisis-induced abstinence, biopsychological stabilization, and the resulting flush of health and great intentions do not constitute sustainable recovery and are as likely to be milestones in one's addiction career as a portal of entry into long-term recovery (Scott, Foss, & Dennis, 2005; Venner, Tonigan, & Feldstein, 2005; White, 2007a).

What is required to sustain recovery is qualitatively different than what is required to initiate recovery (Humphreys, Moos, & Finney, 1995). The acute care model of addiction treatment provides an opportunity for recovery initiation but may or may not exert an influence on the process of recovery maintenance. A growing number of "system-sophisticated" clients have acquired skills in recovery initiation (e.g., "doing treatment") but repeatedly relapse due to their failure to make the transition to recovery maintenance in natural, non-institutional environments. What is needed in such circumstances is not an unending series of treatment episodes (more recovery initiation), but a focus on building the personal, family, and community recovery capital required for long-term recovery maintenance. That process requires interventions at the individual, family, and community levels (White, 2008).

3.5 Catalytic metaphors

Certain words and ideas can, through the power of their cognitive, emotional, and spiritual salience, spark a reconstruction in personal character, identity, interpersonal relationships, and life purpose, and through that process, ignite and sustain the process of addiction recovery (Miller & C'de Baca, 2001). For individuals seeking recovery, such an idea "explains many things for which we cannot otherwise account" (Alcoholics Anonymous, 1939, p. 2). Such metaphors are the building blocks of the story reconstruction and storytelling processes that are a near universal aspect of the recovery process and differ markedly across individuals and cultural groups (White, 1996). Communities can widen the doorways of entry into recovery by expanding the diversity of addiction/recovery metaphors available to its citizens. Treatment institutions can enhance personal/family recovery by assuring that the sense-making metaphors utilized in the service process are culturally transferable to each client's/family's natural environment.

3.6 Physical/psychological/cultural distance

The greater the physical, psychological, and cultural distance between a treatment institution and the natural environments of its clients, the greater is the problem of transfer of learning from the institutional to the natural environment (White, 2002). Community reintegration is enhanced by service organizations whose facilities resemble the surrounding community and

the expected post-treatment environments of their clients and who promote client access to pro-social, pro-recovery activities in these environments (Makas, 1993). Repeatedly re-admitting an adolescent into inpatient addiction treatment (who quickly relapses when discharged into his or her drug-saturated social environment) without shaping the post-treatment environment and supporting recovery within this environment is a form of institutional profiteering, in effect if not intent.

The chasm between institutional and natural environments can be lessened by extending the service process into the daily life of the community and by inviting the community into the daily life of the service institution. One of the factors contributing to the exceptionally high addiction recovery rates within Physician Health Programs is anchoring recovery within the natural environment of each physician via years of post-treatment monitoring, support, and, when required, early re-intervention (White, DuPont, & Skipper, 2007).

3.7 Community as an active recovery ingredient.

The community is not an inert stage on which the trajectories of addiction and recovery are played out. The community is the soil in which such problems grow or fail to grow and in which the resolutions to such problems thrive or fail to thrive over time. That soil contains promoting and inhibiting forces for both addiction recovery. The ratio of such forces can tip the scales of recovery initiation efforts toward success or failure (Sung & Richter, 2006). As such, the community itself should be a target of intervention into AOD problems. At present, claims of cultural ownership of AOD problems is split into ideological camps, including a public health model that focuses on environmental strategies for the management of AOD problems and a clinical model that focuses on the professional treatment of individuals experiencing such problems. There is considerable potential in the integration of these two approaches.

3.8 The contagiousness of recovery

Metaphors of contagion (e.g., *epidemic*, *plague*, and *outbreak*) have long been used to describe the rapid social transmission of AOD problems within local communities—particularly during periods of drug panic (Jenkins, 1994). Recovery is also contagious—is socially transmitted—and can help stem surges in AOD use. A viable goal of AOD-related community intervention strategies is, in the absence of effective prevention, to shorten addiction careers and extend recovery careers. This requires effective strategies of sustained recovery management and service opportunities that turn people who were once addiction carriers into carriers of recovery.

3.9 Potential iatrogenesis of professional intervention

Where professional institutions and services have been over-developed (e.g., have taken over the natural support functions of families, extended families, and indigenous helping institutions), they may inadvertently erode natural support structures, and in so doing, inflict long-term injury on the community (McKnight, 1995). Professional resources should never be used to meet a need that can be met within community relationships that are natural, enduring, reciprocal, and non-commercialized. The goal of professional intervention, based on the ethical values of autonomy and stewardship, is ideally the mobilization of both personal/family resources and community resources to minimize the need for professional assistance. Treatment is best thought of as an adjunct of the community rather than the community being viewed as an adjunct of treatment.

3.10 Communities of recovery

Spiritual, religious, and secular communities of recovery, including rapidly growing online recovery support communities, are increasing in number, diversity, and geographical dispersion in the United States, as are recovery support groups for special populations and needs (Humphreys, 2004; White & Kurtz, 2006a; Kurtz & White, 2007). Yet most of what we know as a professional field about recovery mutual aid is based on studies of Alcoholics Anonymous (A.A.). Early research on A.A. lacked methodological rigor (Emrick, Tonigan, Montgomery, & Little, 1993; Kownascki & Shadish, 1999), but the quality of A.A. studies has improved markedly in the past decade (Humphreys, 2006). The diversity that exists within and across mutual aid societies has yet to be adequately captured in the scientific literature or within the knowledge base of the field's service practitioners (Humphreys, 2004; Kelly & Yeterian, 2008). Other than the possible exception of Narcotics Anonymous, few adaptations of A.A's twelve step program have been rigorously studied, and only a small body of descriptive literature exists on secular and explicitly religious addiction recovery mutual support societies. The challenges in mobilizing the resources of these communities to aid persons entering and leaving addiction treatment include recognizing the legitimacy of these diverse groups, fully integrating a philosophy of choice related to each client's use of these resources, and training staff to be knowledgeable of each group's core ideas, language, behavioral prescriptions, service structures, and meeting rituals (White & Kurtz, 2006a).

3.11 Recovery community building

There are many clients for whom family and community are more a source of sabotage than support for recovery (Falkin & Strauss, 2003). The only solutions intrapersonal models of treatment have to this dilemma are to further bolster the individual's resistance or receptiveness to such forces or challenge the client to change his or her environment. An alternative is to change the family/community recovery environment through three community-level interventions: 1) extending the reach of professionally-directed treatment services into the community, 2) integrating community resources into treatment institutions and the treatment experience, and 3) increasing the role of addiction treatment institutions in recovery advocacy and recovery community building efforts.

4. The Power of Community: A Discussion of Strategies

There are three essential treatment-related strategies to enhance the healing power of community in the long-term recovery process: outreach, inreach, and recovery community building. These broad strategies involve:

- identifying, engaging, and extracting individuals from existing cultures of addiction at the earliest possible stages of problem development or redevelopment (Abdul-Quaderm, Des Jarlais, McCoy, & Velez, 2003; Coviello, Zanis, Wesnoski, & Alterman, 2006),
- suppressing the physical, economic, and cultural conditions within which cultures of addiction flourish (Williams & Laird, 1992),
- cultivating alternative cultures of recovery and enhancing their growth and vibrancy (White, 1996),
- assertively matching and linking individuals and families to one or more cultures of recovery (White & Kurtz, 2006a), and
- providing sustained post-treatment monitoring and support (Dennis, Scott, & Funk, 2003; Cacciola, Camilleri, Carise et al. 2008).

4.1 Outreach

Outreach as defined here is the extension of professional addiction treatment services into the life of the community, including supporting clients within their natural environments following the completion of primary treatment. Through the outreach process, addiction professionals and their representatives (including alumni and volunteers) extend core treatment and recovery support services beyond institutional walls to support individuals estranged from pro-recovery supports within the community. These services potentially span the pre-recovery, recovery initiation, recovery stabilization, and recovery maintenance stages. Examples of such strategies include:

- Directing or participating in recovery-focused community and professional education programs, e.g., www.recoveryiseverywhere.com.
- Developing intervention models for the full range of AOD problems, including mild to moderate problems that may be amenable to resolution strategies other than abstinence-based treatment (McLellan, 2007).
- Promoting screening and brief interventions (high bottom outreach) via primary physicians, hospital emergency rooms, health clinics, and health fairs aimed at early problem identification and resolution (Bien, Miller, & Tonigan, 1993).
- Transcending the dichotomies between harm reduction and abstinence-based treatment and clinical and mutual-aid approaches by developing integrated, staged responses that span the tenure of addiction and recovery careers (Kellogg, 2003; White & Kurtz, 2006a).
- Conducting assertive street and institutional engagement (e.g., crisis centers, jails, homeless shelters, hospitals; low bottom outreach; “recovery priming”) that capitalizes on developmental windows of opportunity within addiction careers to identify, engage, and retain those with AOD problems.
- Improving access via streamlined intake, induction services for those on waiting lists, barrier removal (e.g., for persons with disabilities), and ancillary support services such as transportation and day care.
- Enhancing retention via institutional outreach, e.g., a recovery coach whose job is to regularly monitor, re-engage, and re-motivate.
- Elevating the visibility of local recovery role models in collaboration with local recovery community organizations and recovery ministries.
- Providing service prompts via face-to-face, telephone-based, internet-based, and/or postal contact before all service appointments and rapid contact following any and all missed appointments.
- Delivering services in natural, non-stigmatized sites, e.g., use of satellite clinics, co-location of treatment services within other service settings, e.g., schools, workplaces, churches, health clinics, neighborhood centers.
- Increasing home-based service delivery, e.g., delivering primary treatment services via home visits and via the telephone and internet.
- Maintaining assertive contact with and involving each client’s family and kinship network members in the treatment and post-treatment recovery support process.
- Enhancing staff knowledge of local communities of recovery via expectation that all direct service staff will attend open meetings of local and online recovery support groups at least monthly.
- Developing an assertive approach to continuing care, e.g., post-treatment monitoring and support, stage-appropriate recovery education, and, when needed, early re-intervention (Dennis, Scott & Funk, 2003).
- Delivering post-treatment recovery support services in homes, workplaces, schools, and other natural environments (Foote & Erfurt, 1991).

There is a style of assertiveness reflected in the above prescriptions that contrasts with what has often been a "take it or leave it" attitude of addiction treatment programs toward their clients. This style difference is best illustrated by comparing traditional approaches to "aftercare" to this more assertive style of continuing care. The clinically relevant differences between passive models of "aftercare" and assertive approaches to sustained recovery management are illustrated in Table 2 (adapted from White & Kurtz, 2006a).

Table Two: Traditional Aftercare versus Assertive Recovery Management

Dimension	**Traditional Aftercare**	**Assertive Recovery Management**
Who Receives It	Only clients who "graduate"	All clients admitted for services including those in detox and those leaving against staff advice or administratively discharged
Responsibility for Contact	The client	The service provider
Timing & Duration of Contact	Set schedule, e.g., weekly aftercare group.	Saturation of support in first 90 days following primary treatment using multiple media; individualized schedule of sustained recovery checkups for up to 5 years. Client helps define contact schedule
Choice Related to Recovery Support	Recovery pathway dictated by service professional	Client oriented to multiple recovery support strategies & structures; client chooses
Linkage to Communities of Recovery	Verbal encouragement to attend and get a sponsor	Matching of client to particular support group representative or meeting with monitoring of response
Media	face-to-face (f-2-f) individual or group meetings	Multiple media: f-2-f, telephone, internet, mail
Where	Contact in institutional settings	Contact in natural settings whenever possible
Staff Response to Report of a Client's Relapse	Sadness and regret	Immediate re-engagement via staff-initiated contact
Response at Re-admission	Shaming and repetition of past treatment protocol	Welcoming: Affirmation of re-engagement decision; formulation of an immediate and long-term recovery plan

The technologies used to conduct longitudinal studies of addiction treatment are now capable of generating exceptionally high follow-up rates for five years and longer (Scott & Dennis, 2000). These technologies could be adapted and refined for post-treatment monitoring, support, and early re-intervention. Preliminary reports on such "recovery check-ups" suggest great promise in elevating long-term recovery outcomes for adults (Dennis, Scott, & Funk, 2003) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002). Post-treatment monitoring can be done in a telephone-based format that is both clinically- and cost-effective (Cacciola, Camilleri, Carise et al., 2008; McKay, 2005; McKay, Lynch, Shepard, & Pettinati, 2005). The potential of the internet for such post-treatment support has yet to be fully explored, although

some programs (e.g. Hazelden) are experimenting with the use of such technology and there is a growing body of literature on internet-based screening for alcohol and drug problems (Kypri, Saunders, Williams et al., 2004; Saitz, Helmuth, Aromaa et al., 2004), online recovery support groups (Humphreys & Klaw, 2001; Hall & Tidwell, 2003) and E-counseling (Copeland & Martin, 2004; Griffiths, 2005).

The chaotic lifestyles of the addicted once constituted the rationale for low follow-up rates in treatment outcome studies. Such a rationale is no more acceptable today in the clinical setting than it is in the research setting. The technology exists to maintain indefinite, supportive contact with clients discharged from addiction treatment. What is needed is the professional will, the research-based monitoring protocols, and the funding mechanisms to do it.

4.2 Inreach

Inreach is the inclusion of indigenous community resources within professionally directed addiction treatment. Potential inreach strategies include:

- Engaging family and social network members in the recovery support process (Galanter, Dermatis, Keller & Trujillo, 2002).
- Developing vibrant Consumer Councils and Alumni Associations.
- Providing recovery mentoring to each client via a formal volunteer program that includes alumni association and consumer council members.
- Formalizing relationships with religious, spiritual, and secular recovery mutual aid groups, e.g., regular meetings with Hospital and Institution Committees and other service structure representatives (White & Kurtz, 2006a).
- Encouraging the development of, and formalizing relationships with, local recovery community organizations, recovery support centers, and recovery community institutions e.g., recovery homes, recovery schools, etc. (Valentine, White, & Taylor, 2007).
- Increasing recovery community representation and diversity of such representation at all levels of the treatment organization, e.g., board, staff, volunteer, advisory committee representation.
- Inviting recovery community representatives to educate staff and clients on the varieties of recovery experience.
- Promoting a “choice philosophy” that acknowledges the legitimacy of multiple pathways and styles of long-term recovery (White & Kurtz, 2006b).
- Utilizing recovery-focused assessment instruments and protocols that evaluate the personal, family, and community recovery capital of each client.
- Including indigenous healers within multi-disciplinary treatment and recovery support teams.
- Including primary care physicians in primary treatment and as a mechanism for long-term, health-focused recovery checkups.
- Contracting with recovery community organizations to provide recovery coaching to clients discharged from addiction treatment.

Outreach and inreach are ways to increase boundary transactions between treatment institutions, local communities of recovery, and the larger community. By reversing the status of addiction treatment institutions as closed systems, the community has greater access to the resources of the treatment institution, and the treatment institution and its clients have greater access to and a greater ability to influence long-term sources of recovery support that reside within the community.

4.3 Recovery community building

Recovery community building includes activities that nurture the development of cultural institutions in which persons recovering from severe AOD problems can find relationships that are recovery-supportive, natural (reciprocal), and potentially enduring. While recovery community building can be described in clinical metaphors (e.g., "the community as the client" or "treating the community"), community building represents knowledge and skills not drawn from clinical disciplines. Where addiction treatment has drawn heavily from the disciplines of psychiatry, psychology, and social work; recovery community building draws upon knowledge drawn from public health, sociology, social movements, community development, and community organization. One way to help make this shift in orientation is to think of treatment as a tool to help prepare individuals and families for the recovery process and to think of community building as a way to create a world in which that recovery can occur, be enriched, and be sustained over an indefinite period of time.

The changing status of African Americans, women, and sexual minorities in the United States over the past half century was accomplished first by a change in social consciousness within these respective groups and then by prolonged community building activities. Community building is the process through which historically colonized and marginalized groups redefine themselves, assert themselves, and elevate personal, family, and community health. The cultural development spawned by the civil rights movement, the women's movement, and the lesbian, gay, bisexual, and transgender/transsexual rights movement spawned charismatic leaders, new values, a new lexicon, musical anthems, celebratory art, new cinematic themes and heroes, a retrieval of lost history and culture, new literary genres, and new catalytic symbols and stories. But these movements also had physical places—buildings and neighborhoods—that represented sanctuaries of personal and cultural transformation.

Is it not time such physical and cultural centers for recovery existed that transcend the iconic institutions of a particular recovery fellowship (e.g., Dr. Bob's Home or Stepping Stones)? Is it not time drug-saturated neighborhoods were transformed into a neighborhood in recovery? When recovery advocates walk through dope-copping neighborhoods cleaning up drug paraphernalia and other refuse, they sow seeds of hope that clean up more than the streets. When shooting galleries, crack houses, and after-hours joints are squeezed out by recovery homes, recovery support centers, and recovery infused neighborhoods, the community as well as individuals and families enter a process of recovery.

Community building will require the creation of new social institutions, e.g., recovery community organizations (Valentine, White, & Taylor, 2007) and new service roles e.g. recovery coaches (White, 2006a) that collectively provide physical, psychological, social, cultural, and spiritual sustenance to people in recovery at the same time they advocate for changes in the larger society that benefit those seeking or in recovery. The new addiction recovery advocacy movement represents a form of community building, and the recovery homes, recovery schools, recovery industries, and recovery churches/ministries represent new social institutions through which diverse communities of recovery are acting in concert.

The development of these institutions, particularly those involving housing, encounter initial "not in my backyard" (NIMBY) resistance from the wider community, but such resistance can often be overcome with careful planning, community education, neighborhood-level relationship building, and legal challenges to discriminatory zoning regulations/enforcement. An example of such success is the Oxford House network of more than 1,200 recovery homes in 48 states. These homes, which houses more than 24,000 recovering people per year, have been rigorously evaluated and found to play a significant role in enhancing long-term recovery outcomes (Jason, Davis, Ferrari et al., 2001; Jason, Olson, Ferrari, & Lo Sasso, 2006). Studies of Oxford House and other supportive housing programs have also concluded that: 1) most neighbors in the surrounding community are unaware of the existence of the recovery home, 2) those neighbors who live closest to these homes have the most positive attitudes toward them,

3) there is no effect on crime rates in the surrounding area when a recovery home opens, and 4) property values are unaffected or actually increase in close proximity to such homes (Aamodt & Chiglinksy, 1989; Galster, Tatian, & Pettit, 2004; Jason, Roberts, & Olson, 2005). Neighborhoods and communities draw added value from recovery institutions via increased knowledge about addiction recovery and acceptance of recovering people and through the neighborhood/community service activities rendered by recovering people (Jason, Roberts, & Olson, 2005; Kurtz & Fisher, 2003).

Personal recovery flourishes in communities that create the physical, psychological, and cultural space for recovery to grow and sustain itself. Local communities of recovery and their related social institutions constitute agents of healing in their own right that can serve as both adjuncts and, in some cases, alternatives to professionally-directed addiction treatment. Treatment institutions can play supportive roles in such recovery community building by:

- Confronting AOD promotional forces in the community, e.g., confronting AOD-related marketing that targets vulnerable populations, actively resisting saturation of AOD outlets in communities of color, challenging lax enforcement of AOD laws, creating local bans on AOD promotions such as Ladies Night and happy hour promotions, supporting tax increases on alcohol and tobacco products.
- Collaborating with recovery community organizations to prepare and release an annual community "recovery report card" with data on key recovery benchmark measures.
- Encouraging the development of alternative recovery support groups, specialty meetings, and related structures (e.g., clubhouses; Mallams, Godley, Hall, & Meyers, 1982).
- Forging partnership (non-paternal, non-manipulative) relationships with local recovery community organizations.
- Promoting pro-recovery policies at national, state, and local levels.
- Promoting the development of a full continuum of treatment and recovery support services, including services not related to the financial interests of the treatment institution.
- Providing training and technical assistance to enhance the quality and diversity of local recovery support services.
- Financially contributing to and participating in recovery celebration events.
- Developing special community re-entry supports for those persons seeking recovery following prolonged institutionalization (e.g., Winner's Community).
- Cultivating mechanisms of community reintegration and citizenship, e.g., pro-recovery social activities and opportunities for community service.
- Providing guides that can lead individuals into relationships with one or more communities of recovery and into activities within the larger community that are conducive to long-term recovery.
- Providing outlets for artistic expression of recovery community members through music, art, theatre, literature, and comedy.
- Challenging regulatory policies that lead to the depersonalization of addiction treatment.

In the end, it is the community not the treatment center that can offer those with addiction histories invitation for social inclusion. The treatment center can play a crucial role in shaping a community environment in which people in recovery are welcomed and where recovery can flourish. Tipping the scales of re-addiction or recovery may hinge as much on that environment as the unique assets and vulnerabilities of each client.

5. A Closing Reflection

Addiction treatment institutions that in their founding missions defined themselves as community-based service organizations are today more likely to define themselves as businesses. It is time treatment organizations rebuilt the connecting tissue between themselves and the communities they serve. It is time treatment institutions rediscovered the natural healing powers that lie within the communities in which their clients are nested. When universities became too isolated from the communities they once served, there were calls for these institutions to move back into the life of their communities—to become "universities without walls." It is time we as a professional field begin to think of treatment and recovery without walls (White, 2002). If we achieve that, we will by necessity erase the boundaries that have artificially separated primary prevention, early intervention, treatment, and recovery.

Acknowledgement: This paper was prepared for the Second Betty Ford Institute Consensus Conference: Extending the Benefits of Addiction Treatment: Practical Strategies for Continuing Care and Recovery. October 3-4-, Rancho Mirage, CA. I wish to acknowledge an anonymous reviewer for many helpful suggestions to improve this paper.

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Citation: Erickson, C. & White, W. (2009). Commentary: The neurobiology of addiction recovery. Alcoholism Treatment Quarterly, 27(3), 338-341.

Commentary: The Neurobiology of Addiction Recovery.

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Abstract

An unprecedented investment in research funding has produced stunning revelations about the neurobiological mechanisms of addiction (Nature, 2005). This research buttresses the proclamation that addiction is at its most fundamental level a brain disease and promises a new generation of treatments for addiction (Leshner, 1997). As the focus of addiction science moves to the laboratory, a broader social movement is calling upon those in the alcohol and other drug problems arena to shift their organizing center from a focus on pathology and treatment to a focus on resilience and recovery (White, 2005). Such a shift would require achieving consensus on a definition of recovery (Betty Force Consensus Panel, 2007) and formulating and funding a broad recovery research agenda (Laudet, 2008). This brief commentary summarizes recent findings on the neurobiology of addiction, notes the scant information available on the neurobiology of recovery and identifies key questions in this area that are crucial to the future of addiction treatment and recovery.



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Citation: Molloy, P. & White, W. (2009). Oxford Houses: Support for recovery without relapse. *Counselor*. 11(2), 28-33. Posted at **www.williamwhitepapers.com**

Oxford Houses: Support for Recovery without Relapse

J. Paul Molloy and William L. White

Addiction professionals are painfully aware that addiction treatment is all too often followed by relapse, re-addiction, and readmission to treatment. Of those individuals currently entering addiction treatment in the United States, 52% already have one or more prior admissions to specialty-sector addiction treatment, and 20% have three or more prior admissions (for those with opiates as a primary dependency, the figures are 74% and 42% respectively; OAS, 2007). Of those discharged from addiction treatment, more than half will resume alcohol and/or drug use in the following 12 months, and 50% will be readmitted to addiction treatment within 2-5 years (For an extensive review of this data, see White, 2008). When clients, family members, referral sources, funding authorities, and members of the larger community ask for an explanation of this cycle, they are often told that this pattern marks the very essence of a chronic, relapsing disorder. “Relapse is part of the disease” is prominently featured in the new litany of addiction treatment.

But a growing number of addiction professionals and recovery advocates are asking whether relapse is an inherent quality of addiction or the product of a design flaw in how addiction is treated and managed, or more specifically, treated and not managed. It has been suggested that relapse rates might decline precipitously if individuals who initiate recovery within the context of addiction treatment were afforded access to sustained monitoring, recovery support services, and a post-treatment environment that is supportive of recovery maintenance.

For more than three decades, men and women seeking recovery have been involved in a living experiment that has tested this very proposition. This article will describe how Oxford Houses function as recovery support institutions, and review what scientific evaluations have concluded about the relapse and long-term recovery outcomes of Oxford House residents.

Oxford House History

Oxford Houses are self-run, self-supported recovery houses. Once voted in, residents can stay as long as necessary as long as they do not drink or use drugs, pay their monthly share of expenses, and expel any house member who uses drugs or alcohol. Started in 1975 by a group of men whose stay in a county-run halfway house was abruptly ended when the county

decided to close the house, there are now over 1300 Oxford Houses providing recovery housing.

The first person voted into Oxford House was Jim Spellman. Like most of the other men in the first Oxford House, Jim attended a lot of recovery support meetings and was a popular speaker at open meetings. He would often tell a story – perhaps apocryphal – about Blue Cross-Blue Shield hiring one of the leading consulting firms to study the best solution for the alcoholism/drug addiction problem. He would describe all the surveys they conducted and the experts they consulted, and then he would announce the major finding of the study: "If you don't drink alcohol, you won't get drunk, and if you don't use drugs, you won't get high." Everyone hearing Jim's story would laugh, knowing the truth of the observation and the difficulty in achieving it. For Jim and tens of thousands of others who followed, the difficulty of becoming comfortable enough in sobriety to avoid relapse was overcome by living in an Oxford House.

In 1988, Congress recognized that Oxford Houses worked and included a section based on the Oxford House model in the Anti-Drug Abuse Act of 1988 (Section 2036 – *Group Homes for Recovering Substance Abusers*, now codified in the United States Code as 42 USC 300x-25). That law, along with a minimal amount of technical assistance provided by trained outreach workers, served as a catalyst for the expansion of Oxford Houses throughout the country. The network of Oxford Houses has grown from a handful of houses in the Washington, DC area in 1988 to more than 1,300 houses with a collective daily capacity of 9,922 recovering people across 44 states. As of November 2008, 314 of the homes are for women, and 54 are designed specifically for women and children.

The Oxford Houses are residential single-family houses segregated by gender. They are located in stable neighborhoods. In most cases, trained outreach workers employed by Oxford House, Inc. – the national nonprofit umbrella organization – help establish new houses and train the initial residents to use the time-tested system of disciplined democratic operation and self-support. These trained outreach workers also organize local clusters of houses into mutually supportive chapters and statewide associations.

Growth of the network of Oxford Houses over the last decade shows that clusters of Oxford Houses can be replicated readily at minimal cost. Since all Oxford Houses are *rented,* there is no need for substantial capital investment. Experience has shown that mass expansion requires utilization of trained residents and alumni to effectively establish clusters of houses in new geographic areas. A single outreach worker can open between three to five houses per year. The most effective model for developing local clusters or statewide networks of Oxford Houses includes the involvement of the state addiction treatment authority in providing funding to pay outreach workers and to administer the recovery home revolving loan fund established pursuant to the provisions of the federal Anti-Drug Abuse Act [42 USC 300x-25]. Most of the existing 1,300 Oxford Houses have received and repaid $4,000 start-up loans. These loans enable a new Oxford House group to pay a landlord the first month's rent and security deposit. These loans are then repaid over 24 months at the rate of $170 a month.

How Oxford Houses Operate

The success of Oxford House is rooted in its simplicity and in the infrastructure that supports it. Oxford Houses provide a place for the recovering individual to heal and transform his or her life from one of destructive addiction to comfortable, productive, long-term sobriety. At the same time, Oxford Houses provide residents considerably more personal liberties (e.g., ability to bring belongings, personal choice of daily schedule, freedom to leave for weekends, and "private time" with guests in their room) than would be found in therapeutic communities or

traditional halfway houses (Ferrari, Jason, Davis et al., 2004).

First, a group of recovering individuals must get a charter from Oxford House, Inc. to establish and operate an Oxford House. There is no charge for the charter. Second, the house must be for either males or females – there are no coed houses. Third, the group home must have at least six beds. Fourth, the group must agree to the following three conditions:

1. The house must be democratically self-run,
2. The house must be financially self-supporting, and
3. The group must immediately expel any resident who returns to using alcohol and/or drugs.

The umbrella organization, Oxford House, Inc., has sole authority to issue charters and initially issues a charter limited to six months. During that period of time, the group must take steps to show that it understands how to operate as an Oxford House by following the operational procedures in the Oxford House Manual© and submitting proof of performance to Oxford House World Services. The proof includes two letters of recommendation from active AA or NA members. Then it is given a permanent charter and has equal membership in the network of all Oxford Houses. Oxford House Inc. thanks the recommending AA/NA members and asks them to contact World Services if they ever believe that the house has failed to expel a resident who has relapsed. This is but one part of the quality control mechanisms the central Oxford House organization uses to keep houses on track.

The operation of each Oxford House is based upon a standard system of operation including weekly house business meetings, election of five officers, and prompt payment of all household bills. Each officer has specific duties within the house and each resident is limited to service of six months in any one office. The forms and procedures are the same for each house. Among other duties, houses post their vacancies on the national website: www.oxfordhouse.org.

Prospective Oxford House residents are selected for membership following completion of an application, participation in an interview with existing house members, and approval by 80% of the residents living in the house. In many ways, getting into an Oxford House is similar to getting accepted as a member of a country club or some other exclusive organization. What this process says to the accepted newcomer is that his or her peers want him or her as a member of their family. Being accepted into an Oxford House – in and of itself – is often the new member's first success along the recovery path.

Once accepted as a member of an Oxford House, the recovering individual has an equal voice in the running of the house, including a vote at the regular weekly business meeting. In these meetings, which are run by disciplined parliamentary procedures, everyone in the house reviews the financial status of the house, discusses and votes on key issues facing the house, and participates in solving problems of daily living that arise within the house. The predictability of everyday events in the house adds to the newcomer's transition from the turbulence of addiction to the stability of sobriety. The recovery process within the Oxford Houses has been aptly conceptualized as a transition from destructive drug dependencies to a positive dependence on recovering peers (Nealon-Woods, Ferrari, & Jason, 1995).

Nationally, the average number of residents per house is 8.2. The best size house provides room for 8-12 residents, with most bedrooms accommodating two individuals to help them avoid the isolation that can lead to relapse. Residents pay an average equal share of household expenses (rent to the landlord, loan repayment, utilities, and house staples) of about $95 a week (range from $75 per week to $150 per week). Residents can live in an Oxford House for as long as they stay clean and sober and pay their equal share of

expenses. There are no limits on length of residence in an Oxford House. While the average length of stay is about a year, some residents live in an Oxford House for many years. This open-ended residency is possible because when demand exceeds the supply of beds, the group simply rents another house to establish another Oxford House.

Oxford House Evaluation Studies

When they started the first house, the original group of residents had to prove that 'the inmates could run the asylum.' A full-time staff of three ran the traditional halfway house in which they had lived. The remaining houses not closed by the county also relied on a full-time staff who proclaimed that the Oxford House would soon become nothing but a flophouse for drunks and drug addicts. This voicing of doubt by "the Establishment" spurred the new Oxford House residents into a "We'll show you" attitude. As part of that attitude, the very first Oxford House invited observation by others, made its address public, and kept all records public with regard to its successes and failures. Evaluation was infused within the very bones of the Oxford House culture.

When Bill Spillaine, Ph.D., started teaching at Catholic University after he retired from NIDA, he asked to review the outcome records of individuals who had lived in an Oxford House from its beginning in 1975 through 1987. Everyone living in all 13 Oxford Houses at that time agreed to cooperate with him. Dr. Spillaine tracked down more than 1,200 former Oxford House residents to learn how many had stayed clean and sober. When he came to the leaders of Oxford House and reported that 80% had stayed clean and sober without relapse, the leaders asked, "What are we doing wrong to have 20% of our residents relapse?" Dr. Spillaine explained that the normal rate of sobriety without relapse was less than 20% and that the Oxford House resident outcome was exceptionally good.

Beginning in 1990, Oxford House residents entered into a sustained collaboration with DePaul University psychologists to evaluate all aspects of the Oxford House network. Since then, Leonard Jason and his colleagues have conducted dozens of studies that tracked residents and alumni and compared outcomes of Oxford House residents and control groups of recovering individuals not living in Oxford Houses. (Many of the DePaul Studies are available at www.oxfordhouse.org.) For the most part, Spillaine's early findings have held up, showing that sobriety without relapse is the norm for Oxford House residents.

More detailed findings from the studies conducted by Dr. Jason Leonard and his colleagues at DePaul University's Center for Community Research include the following (excerpted from White, in press):

- Oxford House residents present a profile of gender and ethnic diversity, high alcohol and drug problem severity, and rates of co-occurring psychiatric disorders comparable to addiction treatment populations (Alvarez, Adebanjo, Davidson, et al, 2006; Ferrari, Curtin-Davis, Dvorchak, & Jason, 1997; Jason, Davis, & Ferrari, 2007; Jason, Davis, Ferrari, & Bishop, 2001).
- Alcoholics Anonymous is the dominant framework of recovery for Oxford House residents (76%), but other pathways of recovery are respected (e.g., 17% report individual psychotherapy as their primary recovery support medium; Nealon-Woods, Ferrari, & Jason, 1995).
- At 2-year follow-up, residents who stayed in Oxford House for a minimum of six months following residential addiction treatment have superior recovery outcomes compared to those placed in traditional aftercare (15.6% rate of reported substance use compared to 64.8%). Oxford House residents also achieve higher rates of employment, higher incomes, and a lower rate of

arrest than do those in traditional aftercare (Jason, Olson, Ferrari et al., 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006).

- The prospects of long-term recovery rise with length of stay in an Oxford House (Jason, Davis, & Ferrari, 2007).
- At extended follow-up, 69% of residents remain in residence or have left the house as planned in good standing (Majer, Jason, Ferrari, & North, 2002).
- Oxford Houses for women that accommodate children have a positive effect on both the mothers and on other women in the house (d'Arlach et al., 2006).
- The communal environment of the Oxford House has been found to be particularly congruent to African American men and women and members of other groups whose historical experience has created a distrust of authority figures (d'Arlach et al., 2006; Ferrari, Curtin-Davis, Dvorchak, & Jason, 1997).
- Community attitudes toward Oxford House are most positive among neighbors who live closest to the Oxford House (Jason, Roberts, & Olson, 2005).

Subsequent studies of Oxford House confirm the primary finding of the first study: the vast majority of Oxford House residents stay clean and sober without relapse.

A Closing Reflection

Congress has just mandated that health insurance companies must cover mental illness and substance abuse with the same standards they use to pay for other illnesses (The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 of PL 107- 1434). Passage of this legislation is, in some ways, a step "back to the future" since many health insurance companies in the 1970s and early 1980s covered addiction treatment as they covered payment for other illnesses. Such reimbursement was restricted or eliminated in the late 1980s and early 1990s because of treatment industry excesses (e.g., inappropriate admissions, excessive lengths of stay) and growing alarm about patterns of chronic relapse and treatment recycling. It is important in the face of this new legislation that the treatment field avoids replication of this earlier history. The use of Oxford Houses and other non-clinical, peer-based recovery support services can enhance the likelihood of recovery without relapse and can help prevent the future loss of the parity that has just been legislatively restored.

The website www.oxfordhouse.org contains material showing where Oxford Houses are located, studies showing how local development can take place, research reports verifying best practice for assuring recovery without relapse, and a real-time inventory of vacancies in existing houses. Visit this site to explore how this growing network of Oxford Houses may be of use to your clients who could benefit from such rich recovery support.

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Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation

Executive Summary

William L. White, MA

The history of addiction treatment and recovery in the United States contains a rich "wounded healer" tradition. For more than 275 years, individuals and families recovering from severe alcohol and other drug problems have provided peer-based recovery support (P-BRS). Formal peer-based recovery support services (P-BRSS) are now being delivered through diverse organizations and roles and are emerging as a critical component of "recovery management" and "recovery-oriented systems of care." For the past year, I have researched the history and status of peer recovery support in the United States. The results of this review are now available in a new 250+ page monograph published by the Center for Substance Abuse Treatment's Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services. A PDF of the monograph is available for downloading and hard copies for purchase are both available at www.glattc.org.

This issue of *Counselor* provides an executive summary of the new monograph. I hope it will stimulate much discussion about the history of the role of addiction counselors and the emergence of new models of peer-based recovery support.

Introduction

- The organizing principle for providing care for people with alcohol and other drug problems is shifting from pathology and intervention paradigms to a long-term recovery paradigm.
- Evidence of this shift can be seen in the shift in emphasis within addiction treatment from models of biopsychosocial stabilization to models of sustained recovery management.

- Recovery management models include assertive interventions to shorten addiction careers, lengthen recovery careers, and enhance the quality of individual/family life in long-term recovery.
- Peer-based recovery support (P-BRS) and formal peer-based recovery support services (P-BRSS) constitute central recovery management strategies and a core component of recovery-oriented systems of behavioral health care.
- This monograph reviews the history, operational principles, service practices, and scientific status of P-BRS and P-BRSS as well as their future relationship with professionally-directed addiction treatment.

Chapter One: Defining Peer-Based Recovery Support Services

- Peer-based recovery support (P-BRS) is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from alcohol and/or other drug-related problems.
- Peer-based recovery support is provided by people who are experientially credentialed.
- There are substantial differences between models of peer recovery support and models of professionally-directed addiction treatment.
- P-BRS can be delivered through a variety of organizational venues and a variety of service roles (including paid and volunteer recovery support specialists).
- The governance structures of P-BRS vary in the span and degree of peer control (peer-owned, peer-directed, or peer-delivered).
- Peer-based recovery support services (P-BRSS) are a form of P-BRS delivered through more formal organizations and through more specialized roles.
- Asset allocation schemes for P-BRSS include entrepreneur models (excess assets returned to private owner/investors), institutional models (excess assets reinvested in development of the organization), and stewardship models (excess assets reinvested in recovery community development).
- The core functions of P-BRSS span the stages of recovery initiation/stabilization, recovery maintenance, and enhancement of quality of life in long-term recovery and may encompass support at individual, family, neighborhood, and community levels.
- P-BRSS are distinguished by their recovery focus; mobilization of personal, family, and community recovery capital to support long-

term recovery; respect for diverse pathways and styles of recovery; focus on immediate recovery-linked needs; use of self as a helping instrument; and emphasis on continuity of recovery support over an extended period of time.
- P-BRSS may serve as an adjunct or alternative to professionally-directed addiction treatment.

Chapter Two: History of Peer-Based Recovery Support Services

- Addiction recovery mutual-aid societies and the specialty sector of addiction treatment emerged in response to the social stigma attached to AOD problems and the history of service exclusion, service extrusion, and ineffective and harmful interventions that individuals and families experienced in their encounters with mainstream health and human service institutions.
- Addiction recovery mutual-aid societies have experienced substantial growth (membership size and geographical dispersion of local meetings), pathway diversification (secular, spiritual, and religious recovery societies), specialization (meetings focused on age, gender, drug choice, and special needs), and new support media (growth of telephone- and internet-based support).
- A growing number of religious and cultural revitalization movements are embracing abstinence and creating unique cultural and religious pathways of recovery initiation and maintenance.
- People in recovery have sought service roles as a natural extension of the service ethic within communities of recovery and as a backlash against ineffective and disrespectful professional interventions.
- The services recovering people have provided to individuals and families suffering from AOD problems have emphasized service relationships that are natural, equal, reciprocal, voluntary, sustained (potentially life-long), non-bureaucratic, and non-commercialized.
- P-BRSS constitute an effort to recapture dimensions of support lost in the professionalization of addiction counseling and the weakening of the service ethic within communities of recovery that accompanied the rise of an “alcohol and drug abuse industrial complex” (Hughes, 1974).
- People in recovery have been cyclically included and excluded from leadership and service roles within addiction treatment and the broader arena of recovery support services.

- Recovering people are awakening both politically and culturally and are generating new recovery support institutions that compliment, and in some circumstances, compete with, professionally-directed addiction treatment.
- New recovery support institutions include grassroots recovery community organizations, recovery homes and colonies, recovery industries, recovery schools, recovery ministries and recovery churches, recovery-focused media (radio, television, cinema), and recovery arts (music, literature, film, comedy).
- Recovering people are again moving into a broad range of service roles within addiction treatment and allied health care, human service, and criminal justice agencies.
- Recovery support services are being rapidly privatized and professionalized—a trend with unclear long-term consequences.

Chapter Three: The Theoretical Foundations of Peer-Based Recovery Support

- Some people who survive a life-altering disorder or experience develop special sensitivities, insights, and skills to help others similarly afflicted.
- The zeal recovering people bring to helping others reflects a deep sense of purpose and destiny, as well as a means of making amends for past addiction-related harm to others.
- Addiction counseling and peer recovery support rest on two overlapping, but potentially conflicting, traditions of authority: professional knowledge and experiential knowledge.
- The course and outcome of chronic illnesses are profoundly influenced by the peer support available to individuals and families who experience such illnesses.
- Exposure to the personal stories and lives of people in recovery can serve as a catalyst of personal transformation for people suffering from severe AOD problems.
- Peer recovery support helps to remedy the inequality of power/authority, perceived invasiveness, role passivity, cost, inconvenience, and social stigma associated with professional help for severe AOD problems.
- Peer helping is reciprocally beneficial: the helper and helpee both draw value from helping exchanges.

- In historically oppressed communities, hope for individuals and families is best framed within a broader vision of hope for a people, e.g., attaining social justice; addressing disparities in health, stigma, and discrimination; and widening doorways of community participation and contribution for all people.
- Understanding the ecology of recovery is crucial to the design of effective P-BRSS in all communities.
- P-BRSS provide experience-grounded guidance in the journey from cultures of addiction to cultures of recovery.
- As peer-based recovery support movements develop, they face twin risks: 1) anti-professionalism, "incestuous closure," and implosion; and 2) loss of mission via the forces of professionalization, bureaucratization, and commercialization.
- All peer-based recovery support services rest on the primacy of personal recovery.
- P-BRSS constitute a mechanism of long-term recovery support that can enhance recovery outcomes at costs far less than those of services provided through sustained professional care.

Chapter Four: Studies of the Effects of Participation in Recovery Mutual-aid Societies

- Scientific studies regarding the effects of participation in recovery mutual-aid societies on long-term recovery outcomes are limited in scope and methodological rigor.
- Most of what is known about mutual-aid and recovery outcomes is based on studies of the effects of involvement in Alcoholics Anonymous by individuals treated in professionally-directed addiction treatment programs.
- Participation in recovery mutual-aid societies typically enhances long-term recovery rates, elevates global functioning, and reduces post-recovery costs to society among diverse demographic and clinical populations.
- Individual responses to recovery mutual-aid groups are variable, including those who respond optimally, those who respond partially, and those who fail to respond.
- Recovery mutual aid participation has multiple active ingredients, including motivational enhancement for recovery, reconstruction of

personal identity, reconstruction of family and social relationships, enhanced coping skills, and the personal effects of helping others.

- The effects of recovery mutual aid involvement are interdependent with frequency, intensity, and duration of involvement.
- Combining recovery mutual aid and professionally-directed addiction treatment has additive effects in clinical populations.
- For clients in addiction treatment, affiliation with and benefits from recovery mutual-aid societies are influenced by counselor attitudes toward mutual aid, the style of linkage (assertive vs. passive, degree of choice, and personal matching), and the timing of linkage (during treatment vs. following treatment).
- The Internet may provide an effective adjunctive or alternative delivery device for peer-based recovery support services.
- The potential positive effects of recovery mutual-aid participation are often not achieved due to weak linkage procedures and high early dropout rates.

Chapter Five: Studies of the Effects of Participation in other Recovery Community Institutions

- There is a long history of recovery support institutions beyond mutual-aid fellowships (e.g., recovery community organizations, Recovery Community Centers, recovery-oriented social networking sites, and other online resources), but very little research exists on the effects of involvement in these institutions on long-term recovery.
- Participation in recovery social clubs reduces the risk of relapse following addiction treatment.
- Living within the national network of Oxford Houses significantly reduces the risk of relapse and enhances long-term recovery outcomes.
- Participation in recovery high schools and college/university-based recovery communities reduces the risk of relapse, enhances recovery outcomes, and elevates academic achievement.
- Recovery industries and recovery-conducive employment sites have yet to be described or evaluated extensively in the scientific literature.
- Religion-oriented recovery colonies, recovery ministries, and recovery churches are growing but remain all but invisible to the professional addiction treatment and research communities.

- Recovery support structures organized by and for recovering people within the context of addiction treatment, such as consumer councils and alumni associations, have not been evaluated scientifically.

Chapter Six: Studies of Recovering People Working in Addiction Treatment

- The portrayal of recovering people working in the addictions field is plagued by misconceptions and stereotypes that are contradicted by the available scientific evidence.
- The percentage of counselors in personal recovery within the specialty sector addiction treatment workforce has declined from nearly 70% in the early 1970s to approximately 30% in 2008.
- Recovery status alone does not predict pre-practice educational performance or performance on addiction counselor certification tests.
- Studies of addiction counselors in the United States have found that recovering addiction counselors are *as* effective as counselors who are not in recovery, with neither group showing superiority based only on the question of recovery status.
- The key determinants of effectiveness do not include recovery status. The effectiveness of counselors in personal recovery, like that of counselors not in recovery, varies widely from person to person.
- Recovering people working in addiction treatment are paid less than people not in recovery for comparable work, even when their educational credentials are equal.
- Studies of the personalities of recovering men and women working as addiction counselors reveal few differences from counselors without addiction recovery backgrounds.
- Much of what has been attributed to recovering counselors by way of beliefs and attitudes is a function of educational level; as educational levels of people in recovery have increased, differences between recovering counselors and counselors without addiction histories diminish or disappear completely.
- Attitudes toward evidence-based practices differ by educational levels but not by recovery status (when education levels are controlled).
- People in recovery do not constitute a homogenous group: attitudes/beliefs, clinical effectiveness, and the quality of ethical sensitivity and decision-making cannot be predicted based on recovery status.

- Studies of the relapse rates of recovering addiction counselors over the past 40 years report relapse rates ranging between 5% and 38%, with rates progressively declining through these years.
- The evaluation of treatment models delivered primarily by counselors in personal recovery report recovery outcome rates similar or superior to those of programs whose services are delivered by counselors without recovery backgrounds.
- Volunteer programs in addiction treatment relying primarily on volunteers in personal/family recovery have been evaluated positively; volunteer programs declined in popularity within the field throughout the 1980s and 1990s but are increasing in tandem with renewed calls for peer-based recovery support services.

Chapter Seven: Recent Studies of Recovery Coaching and P-BRSS

- There are currently two federal programs administered by the Center for Substance Abuse Treatment that fund initiatives that emphasize peer-based recovery support services: the Recovery Community Services Program (RCSP) and the Access to Recovery (ATR) Program.
- Studies have not been conducted to determine the effects of RCSP or ATR services on long-term recovery outcomes.
- There are independent studies of particular peer-based recovery support services that have been linked to enhanced engagement, access, treatment completion, and improved long-term recovery.

Chapter Eight: A P-BRSS Research Agenda

- There are increased calls for a recovery-focused research agenda capable of illuminating the prevalence, pathways, styles, and stages of long-term individual/family recovery from severe AOD problems.
- Research on naturally occurring recovery communities is best conducted with the sensitivities and methods recently developed for the study of other ethno-cultural communities.
- A research agenda related to P-BRS and P-BRSS must encompass expanded research on the effectiveness of recovery mutual-aid societies (particularly non-12-Step recovery support groups); the role of other recovery community support institutions in long-term recovery; the influence of recovery representation at board, executive,

staff, and volunteer levels on recovery outcomes of service consumers; individual factors affecting the degree of effectiveness of P-BRSS; the effectiveness of particular P-BRSS across the stages of recovery; the relative potency of key recovery support service ingredients; the relationship of P-BRSS to professional treatment; the effects of P-BRSS on family health and functioning; and the influence of organizational context on the effectiveness of P-BRSS.

- Research should also identify the major sources of resistance to P-BRSS and the most effective methods of implementing P-BRSS.
- The recovery research agenda must encompass studies of recovery at individual, family, and community levels.

Chapter Nine: Summary and Conclusions

Specialized addiction treatment grew out of the failure of the mainstream health and human service system to provide effective solutions for individuals and families experiencing alcohol and other drug problems. Today, peer-based recovery support services are growing out of the failure of professionally-directed addiction treatment to provide a continuum of care that is accessible, affordable, and capable of helping people with the most severe and complex AOD problems move beyond brief episodes of recovery initiation to stable long-term recovery. P-BRSS are specifically designed to reach people earlier in their addiction careers, enhance recovery initiation and stabilization, improve linkage to recovery mutual-aid groups and other recovery support institutions, facilitate the transition to successful recovery maintenance, and enhance the quality of personal and family life in long-term recovery.

However, this model is not a panacea. We would do well to avoid the superficial infatuation with P-BRSS that marked the infatuation with recovering alcoholics and ex-addicts in the late 1960s and early 1970s in the rise of modern addiction treatment. The value of P-BRSS is found in identifying what those in recovery specifically bring to the helping process.

Peer-based models of care can have a transforming effect on larger systems of care and on our society by enhancing long-term addiction recovery outcomes and elevating public and professional perceptions of hope for recovery. However, peer models of recovery support can also be corrupted and devoured by larger systems of care. As peer-based services are integrated into the existing treatment system or offered by free-standing independent organizations, there will be pressure to emulate the ethos of the

existing treatment system, including the professional roles of counselors and others.

At the dawn of modern addiction treatment, observers suggested that one of the advantages ex-addict counselors brought to their role was that they were "unencumbered by 'professionalism' and entanglement in bureaucracy" and were free to "interact with patients in a less formal, more spontaneous fashion than professionals" (Suchotliff & Seligman, 1974). Care must be taken not to over-professionalize P-BRSS roles and replicate the very conditions out of which these peer-models were spawned. It will be very important to achieve a delicate balance between peer-based and professional service models, to retain the strengths of each, and manage the vulnerabilities inherent in each model.

Delivering P-BRSS can enrich an individual's own recovery experience, but this work can also be a threat to one's sobriety. In P-BRSS models, service accessibility, availability in time of crisis, and continuity of contact over time constitute distinctive strengths, but they also provide a potential source of over-extension and burnout for individual workers and their organizations. There is an inevitable strain between accessibility and stewardship of resources as organizations providing P-BRSS define their recovery support capacity (How many people? How many services? How long?). P-BRSS are based on the power of mutual identification—a relationship that is personal, reciprocal, and prolonged—but these same traits are potential sources of boundary ambiguity, abuse of power, and moving beyond the boundaries of personal competence. That is why training, guidelines, and supervision are as important for P-BRSS as for professional services.

Rather than view peer-based and professional-based styles of knowing and doing as antagonistic models that must be judged against one another in terms of superiority and inferiority, it is more helpful to view these approaches as complementary, what one of the field's pioneers referred to as a "creative fusion of heart and mind" (McGovern, 1992).

Peer-based recovery support services can help shift the larger treatment system from a focus on brief biopsychosocial stabilization to a focus on the long-term recovery process. Peer-based models can inject a recovery focus—a source of renewal—into treatment institutions whose fear of the current climate of financial scarcity has driven them into excessive preoccupation with paper, profit, and professional prestige. P-BRSS specialists can help divert excessive attention from "funding streams," "product lines," and "bottom lines" and refocus attention on long-term recovery pathways and processes for individuals and families. This must be

done in a way that avoids the "us and them" polarizations between peer and professional models of recovery support.

The addictions field brings one unique quality that separates it from peer models that are rising in allied fields. It has the oldest and largest recovery mutual aid network in the world via the growth of spiritual, secular, and religious recovery mutual-aid groups and new recovery support institutions. We must be very careful that new peer-based models capitalize upon the strength of these communities of recovery rather than undermining or replacing them. Our long-term goal is not to create a larger treatment system or a new profession, but to create the physical, psychological, and social space in which recovery flourishes in local communities.

Note: The monograph summarized here was prepared with the support of the Philadelphia Department of Behavioral Health and Mental Retardation Services and the Great Lakes Addiction Technology Transfer Center under a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the views of the author and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: DuPont, R.L., McLellan, A.T., White, W.L., Merlo, L.J. & Gold, M.S. (2009). Setting the standard for recovery: Physician Health Programs, *Journal of Substance Abuse Treatment*, 36, 159-171.

Setting the Standard for Recovery: Physician Health Programs

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Abstract

A sample of 904 physicians consecutively admitted to 16 state Physicians' Health Programs (PHPs) was studied for 5 years or longer to characterize the outcomes of this episode of care and to explore the elements of these programs that could improve the care of other addicted populations. The study consisted of two phases: the first characterized the PHPs and their system of care management, while the second described the outcomes of the study sample as revealed in the PHP records. The programs were abstinence-based, requiring physicians to abstain from any use of alcohol or other drugs of abuse as assessed by frequent random tests typically lasting for 5 years. Tests rapidly identified any return to substance use, leading to swift and significant consequences. Remarkably, 78% of participants had no positive test for either alcohol or drugs over the 5-year period of intensive monitoring. At post-treatment follow-up 72% of the physicians were continuing to practice medicine. The unique PHP care management included close linkages to the 12-step programs of Alcoholics Anonymous and Narcotics Anonymous and the use of residential and outpatient treatment programs that were selected for their excellence.



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Citation: Johnson, R., Martin, N., Sheahan, T., Way, F. & White, W. (2009) Recovery Resource Mapping: Results of a Philadelphia Recovery Home Survey. Philadelphia, PA: Philadelphia Department of Behavioral Health and Mental Retardation Services. Posted at **www.williamwhitepapers.com**

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:

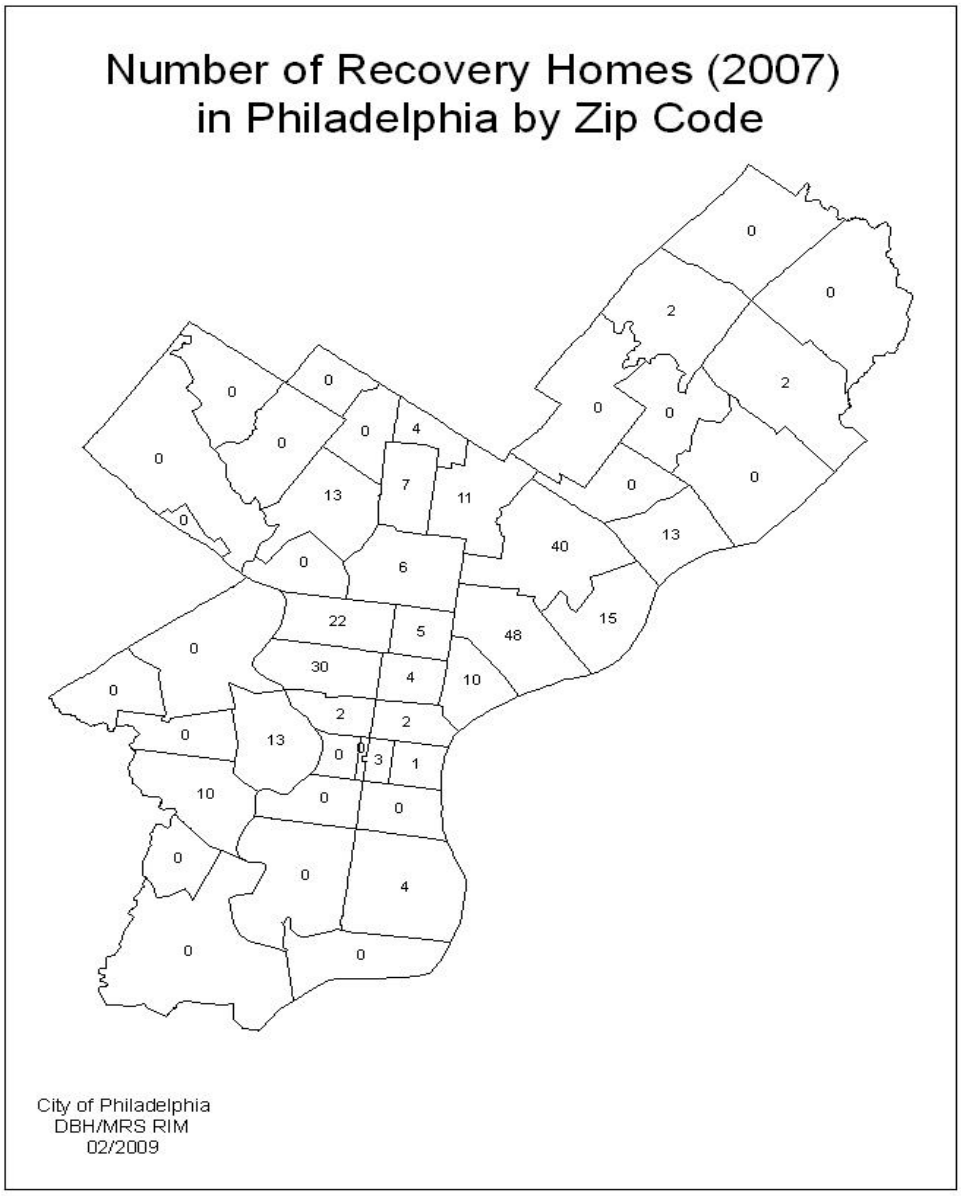
- Does the recovery home have a working relationship with the local welfare office?
- Are the neighbors aware that this is a recovery home?
- What is the degree of support or opposition from the neighborhood?
- Is the home involved in any neighborhood or community service activities as a means of "giving 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.

Acknowledgment: Support for the development of this paper was provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services. The following individuals provided assistance on data collection for this paper: Samuel J. Cutler, Office of Addiction Services, Philadelphia Department of Behavioral Health and Mental Retardation Services, Fred

Martin and Vivian Dantzler of PRO-ACT, and Michael Urciuoli, Crime Analysis and Mapping Unit, Philadelphia Police Headquarters.

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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)**



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Laudet, A.B., Becker, J.B. & White, W.L. (2009) Don't wanna go through that madness no more: Quality of life satisfaction as a predictor of sustained substance use remission. *Substance Use and Misuse*, 44(2), 227-252.

Don't Wanna Go through that Madness No More: Quality of Life Satisfaction as a Predictor of Sustained Substance Use Remission

Abstract

Individuals who have developed a clinical dependence on drugs and/or alcohol often report that they sought help because they were "sick and tired of being sick and tired." Quality of life (QOL) remains the missing measurement in the addictions arena. The few studies conducted to date show that QOL is typically poor during active addiction and improves as a function of remission. An intriguing question bears on the role of QOL in subsequent remission status. Reasoning that higher life satisfaction may "increase the price" of future use and thus enhance the likelihood of sustained remission, this exploratory study tests the hypotheses that QOL satisfaction prospectively predicts sustained remission, and that motivational constructs mediate the association. Inner city residents (N = 289, 53.6% male, mean age 43) remitting from chronic and severe histories of dependence to crack and/or heroin were interviewed three times at yearly interval beginning in April 2003. Logistic regression findings generally support our hypotheses: Controlling for other relevant variables, baseline life satisfaction predicted remission status 1 and 2 years later and the association was partially mediated by motivation (commitment to abstinence) although the indirect effect did not reach statistical significance. Findings underline the importance of examining the role of QOL satisfaction in remission processes. Limitations of this exploratory study are discussed, including the use of a single-item global life satisfaction rating; suggestions for future studies are discussed including the need to embrace QOL as a bona fide clinical outcome and to use comprehensive standardized QOL measures that speak to individual dimensions of functioning. Implications are noted, especially the need for the addiction field to continue moving away from the pathology-focused model of care toward a broader model that embraces multiple dimensions of positive health as a key outcome.



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Citation: White, W.L., Evans, A.C. & Lamb, R. (2009). Reducing addiction-related social stigma. *Counselor*, 10(6), 52-58. Posted at **www.williamwhitepapers.com**

Reducing Addiction-related Social Stigma

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There is no physical or psychiatric condition more associated with social disapproval and discrimination than alcohol and/or other drug dependence (Corrigan, Watson, & Miller, 2006). Addiction-related social stigma constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the cultural resources allocated to alcohol- and other drug-related problems. Efforts to forge "recovery-oriented systems of care" inevitably confront social stigma as a barrier to shaping community attitudes and policies supportive of long-term addiction recovery. The purpose of this article is to highlight some of the modern research on addiction-related social stigma and outline actions addiction professionals can personally take to reduce such stigma within their communities.

Stigma 101

Stigma Defined: Stigma is the experience of being held in contempt (shunned or rendered socially invisible) because of a socially disapproved status (Sayce, 1998). It involves processes of labeling, stereotyping, social ostracism, exclusion, and extrusion—the essential ingredients of discrimination. There are three types of personal stigma: 1) *enacted stigma* (direct experience of ostracism and discrimination, e.g., social rejection; professional disrespect; difficulty acquiring employment, housing or services; denial of governmental benefits—student loans, public housing, small business loans), 2) *perceived stigma* (perception of stigmatized attitudes held by others toward oneself), and *self-stigma* (personal feelings of shame) (Luoma, Twohig, Waltz et al., 2007).

Stigma and Recovery: Addiction-related social stigma extends to people who have achieved stable recovery from addiction (Tootle, 1987).

Courtesy Stigma: The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities. Goffman (1963) referred to this stigma by association as "courtesy stigma." The social stigma attached to families affected by addiction carries the implication that the family

somehow failed to prevent this problem, contributed to its onset, and/or played a role in failing to prevent or inciting relapse episodes. Children may be socially shunned due to the perception that they have been contaminated by the addiction of their parents or siblings (Corrigan, Watson, & Miller, 2006).

Multidimensional Stigma: The weight of addiction-related social stigma is not equally applied. Its burdens fall heaviest on those with the least resources to resist it, e.g., those for whom stigma is layered across multiple conditions (addiction, mental illness, HIV/AIDS, incarceration, minority status, poverty, homelessness) (Yannessa, Reece, & Basta, 2008). Persons experiencing such layered, multidimensional stigma are less likely to seek addiction treatment than persons experiencing a single discredited condition (Conner & Rosen, 2008). The most intense social stigma attached to addiction begins at the point of admission to treatment (a social signal of problem severity) and intensifies with multiple treatment episodes (a social signal of treatment failure) (Luoma, Twohig, Waltz et al., 2007). The social stigma attached to illicit drug use varies by drug and method of ingestion in the U.S., with use of heroin and crack cocaine being the most stigmatized substances and injection the most stigmatized method of ingestion (Surlis & Hyde, 2001).

Greater addiction-related stigma may also be extended to people in particular treatment modalities. Stigma is particularly severe for persons whose treatment and recovery is supported by methadone, in spite of the well-established scientific legitimacy and effectiveness of methadone treatment (Joseph, 1995; Murphy & Irwin, 1992; Woods, 2001). Methadone-related stigma generates a wide span of discrimination—spanning employment, child custody, access to other forms of addiction treatment, and even denial of the privilege to speak at some recovery fellowship meetings (Hettema & Sorenson, 2009; Joseph, Stancliff, & Langrod, 2000).

Stigma and Long-term Health: Stigma can elicit social isolation, reduce help-seeking, and compromise long-term physical and mental health (Ahern, Stuber, & Galea, 2007). Social stigma is a major factor in preventing individuals from seeking and completing addiction treatment (Luoma et al., 2007). Social stigma increases the service needs of persons with substance use disorders, but that same stigma decreases access to such services by fostering social rejection and discrimination (van Olphen, Eliason, Freudenberg, & Barnes, 2009).

Personal Responses to Stigma: Individual strategies to deal with stigma include:

- secrecy/concealment
- social withdrawal
- preventative disclosure
- compensation (using personal strengths in another area to counter the imposed stigma)
- strategic interpretation (comparing oneself to others within the stigmatized group rather than to those in the larger community), and
- political activism (Shih, 2004).

Stigma and Cultures of Addiction: Individuals who share the "spoiled identity" of addiction have historically organized their own countercultures marked by distinct language, values, roles, rules (behavioral codes), relationships, and rituals (White, 1996). These subcultures provide shelter from stigma; access to drug supplies; social support for sustained drug use; meaningful roles, activities, and relationships; and mutual protection. Within these cultures, drug users protect their own identities by stigmatizing other drug users viewed as less in control of their drug use (Boeri, 2004; Simmonds & Coomber, 2009). Such attitudes can get played out within the social pecking order of drug treatment milieus. "Street cultures" are also imbedded with myths designed to inhibit treatment-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement, e.g., street myths about methadone—"it rots your teeth and bones" (Rosenblum, Magura, & Joseph, 1991).

Strategies to Address Social Stigma: Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) protest, 2) education, and 3) contact (Corrigan & Penn, 1999). One major strategy, seeking to inculcate the belief that alcohol and drug addiction is a disease, has not been consistently shown to produce sympathetic attitudes toward those with severe alcohol and other drug problems (Cunningham, Sobell, & Chow, 1993). One of the most effective strategies to reduce social stigma is to increase interpersonal contact between mainstream citizens and people in recovery (Corrigan, 2002). Contact between stigmatized and nonstigmatized groups as a vehicle of stigma reduction is most effective when this contact is: between people of equal status (mutual identification), personal, voluntary, cooperative, and mutually judged to be a positive experience (Couture & Penn, 2003). Social stigma is particularly influenced by social proximity and distance. For example, community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses (Jason, Roberts, & Olson, 2005). Reducing social distance and increasing interpersonal contact are important goals of any anti-stigma campaign.

Historical/Sociological Perspectives

Before exploring personal strategies that addiction professionals may use to address addiction/treatment/recovery-related social stigma in their own communities, it may be helpful to set this issue within a larger perspective.

Social stigma toward alcohol and other drug (AOD) addiction may be defined as an obstacle to problem resolution or as a strategy of problem resolution. The stigmatization and criminalization of alcohol and other drug problems in the United States has grown over more than two centuries as an outcome of a series of "drug panics" and resulting social reform campaigns (Jonnes, 1996; Musto, 1973). These campaigns have generated policies of isolation, control, and punishment of drug users (White, 1979). Stigmatization is not an accidental by-product of these campaigns. It is a reflection of policies that "unashamedly aim to make the predicament of the addict as dreadful as possible in order to discourage others from engaging in drug experimentation" (Husak, 2004). An outcome of this complex social history is that many addiction professionals and recovery advocates see the stigma produced by "zero tolerance" policies as a problem to be alleviated, whereas preventionists see the stigma produced by such policies as a valuable community asset. A key question thus remains, "How do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities?"

Efforts to increase or reduce stigma attached to illicit drug use may have intended or unintended side-effects (Room, 2005). Two examples illustrate this point. First, efforts to decrease illicit drug use by portraying the drug user as physically diseased, morally depraved, and criminally dangerous may inadvertently decrease help-seeking behavior by creating caricatured images of addiction with which few people experiencing AOD problems identify. Such strategies may also promote patterns of social exclusion and discrimination within local communities that block the ability of drug-dependent individuals to re-enter mainstream community life.

Second, an anti-stigma campaign could inadvertently increase drug use if it normalized illicit drug use, increased non-user curiosity about drug effects, conveyed the impression that addiction treatment is an assured safety net (available and affordable) and that recovery is easily attainable, and glamorized the recovering addict as a heroic figure within cultural contexts in which few heroic models are available.

Any campaign to counter addiction/treatment/recovery-related stigma must ask the question, "Who profits from stigma?" Efforts by one group to define another group as deviant can serve psychological, political, and economic interests.

Put simply, stigmatizing others often serves to increase the self-esteem of the stigmatizer (Tajfel & Turner, 1979). It elevates oneself as more worthy than the demeaned "other" and defines oneself as an upholder of community health and morality. Social scapegoating of others increases during periods in which personal esteem, security, safety, and social value are threatened. Participation in or support of campaigns to define others as outsiders serves to confirm one's own insider status. Addiction professionals seeking to reduce social stigma attached to addiction/treatment/recovery must address such issues of esteem, security, safety, and social value. Stigma has political utility. Anti-drug campaigns often mask and reflect deeper conflicts of gender, race, social class, and generational conflict. Such issues have long been manipulated for political gain. Stigma is often the delayed fruit of anti-drug campaigns waged for the benefit of those seeking to build or retain political power. Anti-stigma campaigns must address the question of how the community and its political leaders can benefit from changes in attitudes toward addiction/treatment/recovery. Social stigma can be fed by individuals and institutions whose economic interests are served by such attitudes. Changes in attitudes can trigger shifts in cultural ownership of alcohol and other drug problems and, in that process, shift millions of dollars in ways that affect the destinies of individuals, organizations, and whole communities. For example, past changes in community attitudes have shifted millions of dollars between community-based addiction treatment and the criminal justice system. Such shifts influence the fate of professional careers, organizations, and in some cases, entire community economies. Similarly, what may be viewed as a problem of "not in my back yard" (NIMBY) prejudice by citizens of a particular neighborhood may actually reflect opinion being manipulated by hidden financial interests, e.g., developers who would profit from future gentrification of a neighborhood targeted for a new addiction treatment facility.

Social stigma attached to addiction/treatment/recovery involves complex issues, but each of us may find simple steps we can take to help create a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated" (SAMHSA, 2002).

Twelve Personal Strategies

Addiction professionals and recovery advocates in the City of Philadelphia are engaged in a sustained conversation about addiction-related stigma. We are exploring how to best shape community attitudes and policies to transform the city into a true community of recovery. Some of the ideas we are hearing about how addiction professionals and recovery advocates can contribute to this effort include the following.

1. Assess Yourself. Explore (self-inventory) how addiction-related stigma may have inadvertently influenced your personal (and your program's) attitudes, beliefs, and practices.

2. Stay Recovery Focused. Keep your own batteries charged by staying in touch with individuals and families in long-term recovery, e.g., attending open meetings of local recovery fellowships and/or recovery celebration events.

3. Build Respectful Partnerships. Cultivate service relationships marked by respect, choice, and continuity of support.

4. Make Amends. Acknowledge and correct mistakes and shortcomings in your relationships with people who are seeking or in recovery.

5. Be a Recovery Carrier/Witness. Tell stories of individual and family recovery at every opportunity. The most singularly important thing you have to offer individuals, families, and your community is *hope*.

6. Walk the Walk. Conduct yourself in the community as an ambassador of the recovery movement, conveying as best you can such core recovery values as humility, honesty, gratitude, respect, tolerance, responsibility, and service. Never forget that people will judge those you serve, your organization, and your profession by how you conduct yourself in the community.

7. Model Non-stigmatizing Language. Use language that is medically descriptive rather than moralistic, e.g., "addiction," "drug dependence," or "substance use disorder" rather than "drug abuse." Refrain from language that equates methadone with heroin, e.g., avoid references to methadone treatment as a "substitution therapy" or "replacement therapy" (Maremmani & Pacini, 2006). Use "person first" language in inter-professional and community-level communications, e.g., "person with a substance use disorder" or "person experiencing drug-related problems" rather than "substance abuser" or "addict." Confront language in the treatment milieu that demeans and objectifies, e.g., references to persons re-admitted for treatment as "frequent flyers" or "retreads."

8. Educate Yourself. Seek educational opportunities to increase your knowledge about addiction, treatment, and recovery—particularly on subjects about which you have great passion but little education. Passionate opinion in the absence of knowledge is not an admirable trait of the addictions professional or recovery support specialist.

9. Be an Educator. Seek out opportunities to educate allied professionals, other community service workers, and the larger community about addiction, treatment, and recovery. Use encounters with addiction/treatment/recovery stereotypes in the community as educational opportunities, but be careful to speak only within the boundaries of your education, training, and experience. It is far better to declare, "I don't know" than to convey an ill-informed opinion.

10. Extol the Honor of Service Work. When talking about your work with other professionals and members of the community, emphasize points that will enhance optimism about long-term recovery and the importance of, and personal satisfaction that can be drawn from, professional/personal support of long-term recovery efforts.

11. Be an Advocate. Speak out against stigma-related discrimination, e.g., in housing, employment, government benefits, access to health and human services, *and* in stigma-shaped policies/practices within addiction treatment.

12. Embrace and Promote Diverse Pathways for Recovery. Avoid polarized "either/or" debates about *the* way to treat addiction or *the* way to recover. Our best message is: *There are many pathways to addiction recovery, and all are cause for celebration*. Help people see that there are others like themselves in recovery who share their world view, whether that view reflects a secular, spiritual or religious orientation.

13. Challenge Institutions. Don't assume that institutions in the treatment field or that should otherwise "know better" don't stigmatize people in the same way that the broader society does. Stigma is pervasive and the attitudes of even well-meaning individuals and institutions may unconsciously reflect such stigma.

14. Join the Movement. Participate in local recovery advocacy organizations and grassroots anti-stigma campaigns. Contribute your time, talent, and money to support such efforts. (See www.facesandvoicesofrecovery.org)

Closing Reflection

The social stigma attached to addiction exists at cultural, institutional,

interpersonal, and intrapersonal levels; potential antidotes to such stigma must work at these same levels (Woll, 2005).

Too many of us hide within our own professionally and socially cloistered worlds while boldly challenging our clients to re-enter the life of communities from which we have long been disengaged. We need to reenter those communities and stand in partnership with those we serve to confront the social stigma attached to addiction/treatment/recovery. It is not enough to personally help each client initiate a recovery process. We need to assure a community/world that welcomes and nourishes such recoveries. As part of our larger recovery-focused systems transformation process, the City of Philadelphia is exploring development of a long-term strategy to reduce the stigma attached to addiction/treatment/recovery. Other communities across the country are involved in similar efforts. We hope this opening discussion will stimulate your own thinking about how you can contribute to this movement.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Schulstad, M. (2009) Relapse following prolonged addiction recovery: Time for answers to critical questions. *Counselor*, 10(4), 36-39. Posted at **www.williamwhitepapers.com**

Relapse Following Prolonged Addiction Recovery: Time for Answers to Critical Questions

William L. White and Mel Schulstad

Mrs. Marty Mann, the "First Lady of Alcoholics Anonymous" and founder of today's National Council on Alcoholism and Drug Dependence (NCADD), was perhaps the most singular figure in the advocacy movement that laid the foundation for modern addiction treatment. Her tenacious public education and policy advocacy efforts—always buttressed by her personal witness of recovery— brought hope and resources to millions of American citizens suffering from alcoholism. When a definitive biography of Mann was finally published, it revealed a carefully guarded secret: Marty Mann had experienced a brief relapse at the height of her work with NCADD (Brown & Brown, 2001). Few details are known about Mann's relapse episode other than its brevity and its potential link to her use of alcohol-based medicine. Cases of relapse following prolonged sobriety remain shrouded in mystery at personal, professional, and cultural levels.

Addiction treatment and the larger alcohol and other drug (AOD) problems arena in America have undergone dramatic and sometimes sudden shifts in philosophy and policy over the past two centuries. There is, however, a central theme within this history that has remained unchanged. The knowledge upon which the field has evolved is drawn primarily from the study of addiction-related pathologies and clinical interventions aimed at acute biopsychosocial stabilization. As a field, we know a great deal about addiction and the processes of brief professional intervention, but we know very little about the pathways and processes of long-term recovery. T

he present paper, and the series of which it is a part, calls upon the field to extend (if not shift) its organizing center from these pathology and intervention paradigms to a recovery paradigm (Laudet, 2008; Laudet et al., 2009; White, 2006, 2007, 2008,a, b, in press; White & Chaney, 2008; White & Godley, 2007). Millions of individuals and families in sustained recovery from severe AOD problems have learned important lessons about how to navigate the long-term recovery process; yet their voices are absent from the field's research and popular discourse. As a result, individuals and families in recovery face

critical decisions regarding their health, family life, faith, work, and play without a science of long-term recovery to guide these decisions. The time for research and treatment authorities—the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Center for Substance Abuse Treatment as well as state authorities and private foundations—to pursue a recovery-focused research agenda is long overdue.

The authors have been deeply blessed by having spent (between us) more than 75 years in the addictions field in clinical, administrative, research, and teaching roles. Our lives have been filled with close association with thousands of addiction professionals and people in recovery, including people from a wide variety of religious, spiritual, and secular recovery support groups. Due to our elder status, we are often contacted when questions arise outside the window of the field's core knowledge. The shared stories and questions posed in these emails, phone calls, and face-to-face conversations provide a rare and unsettling glimpse into the darker corners of our field—corners seldom illuminated by the field's professional texts, journals, or conferences. One of the most poignant issues brought to us is that of late-stage relapse (LSR)—defined here as lapse/relapse after a prolonged period (more than five years) of seemingly stable recovery.

Existing research suggests that the risk of future lifetime relapse declines to below 15% for those who have achieved 5 years of continuous sobriety (see White, 2008 for a review), but those people who do experience relapse after years of recovery remain a mystery within the worlds of addiction research, addiction treatment, and recovery mutual aid fellowships. An important item within any recovery research agenda is the phenomenon of LSR. Here are some of the unanswered questions we believe are critically important.

Prevalence

- What is the prevalence of relapse across the life cycle of recovery? Are there points of vulnerability identifiable by age or length of sobriety?
- Does the rate of LSR differ by primary drug(s) involved in past dependence?
- Does the rate of LSR following alcohol dependence differ by pattern/type/severity of alcohol dependence?
- Does the rate of LSR differ across religious, spiritual, and secular frameworks of recovery (or across particular recovery mutual aid societies)?
- What are the particular characteristics of recovery support groups associated with the highest and lowest rates of LSR?
- Do LSR prevalence rates and points of vulnerability differ by gender, race/ethnicity, sexual orientation, or presence of co-occurring medical or psychiatric disorders?

Etiology, Course, and Consequences

- Does LSR in young adulthood differ from LSR in midlife or late life?
- Are there critical transition points from recovery initiation/stabilization to recovery maintenance and from recovery maintenance to enhanced quality of life in recovery that constitute periods of increased risk of relapse?
- Is LSR related to disengagement from active involvement in recovery mutual aid societies and other recovery support relationships/activities?
- Is there a relationship between LSR and physical and emotional distress linked to onset or progression of physical illnesses and their treatment? (e.g., medication for acute or chronic pain)?
- Is there a relationship between LSR and changes in intimate and social relationships (e.g., separation, divorce, or death of one's intimate partner; separation from or death of a

friend or sponsor; onset of new intimate or social relationships)?

- Is there a relationship between LSR and major life transitions, (e.g., death of a parent or sibling, children leaving home, "midlife crisis," geographical relocation, menopause, occupational displacement, retirement, diagnosis of terminal illness)? Is there a relationship between LSR and the presence or loss of religious faith? Does religious faith constitute a protective shield against LSR? To what extent is LSR linked to past sources of emotional pain, particular blocks to developmental maturity, or the failure to master particular developmental tasks of long-term recovery?
- What factors, other than the above, are linked to LSR?
- What are the common trajectories of LSR in terms of duration, intensity, consequences, and outcomes?
- What is the speed of progression from lapse (return to use) to relapse (compulsive use and problem development) in LSR? What is the long-term prognosis for recovery following restabilization after LSR? To what extent is the outcome of LSR influenced by the family, professional, and social response to it?
- What is the effect of LSR on the family?
- What are the effects of a sponsor's LSR on his or her sponsee, home group members, and the fellowship's reputation in the local community?
- What are the mortality rates associated with LSR (e.g., death by overdose, trauma, disease, suicide)?
- How does the prominent coverage of LSR among celebrities (but failure to report on the lives of people in long-term recovery who do not relapse) influence cultural views on addiction and recovery?

Intervention and Treatment

- Are models of family-based, systematic encouragement (e.g. CRAFT) effective in re-involving a family member in professional treatment and/or recovery mutual aid following LSR?
- What are shared issues commonly confronted in the treatment of LSR, e.g., isolation, shame, loss of status, depression, suicidal ideation, etc.?
- Does past familiarity with local treatment and recovery support societies constitute an obstacle to re-initiation of recovery following LSR? If so, what strategies can be used to overcome this obstacle?
- How can the client entering treatment following LSR who has extensive knowledge of addiction and recovery be effectively engaged and counseled?
- How do treatment outcomes differ following LSR than for those newly entering recovery following professional treatment? Do those outcomes differ if the person experiencing LSR was working in the addictions field at the time of the relapse?
- What are the factors associated with successful re-initiation of recovery following LSR?

Self-Management

- As one's life is filled or refilled with work, love, children, and activities in the community, how does one continue to integrate recovery into an expanding quality of life?
- How can the LSR risk and experience be best conveyed to enhance the vigilance of others in recovery?

People in late-stage recovery (more than 5 years) and very late-stage recovery (more than 20 years) appear in only a small number of the field's research studies. There

is no science-based cartography of recovery— particularly later stage recovery. Beyond the folk wisdom found in recovery support groups, little is available to guide professional interventions and peer-based supports for individuals and families experiencing LSR. It is time we answered questions related to late-stage relapse and the most effective responses to it.

As a field, we need a new vanguard of addiction scientists who redefine themselves as addiction recovery scientists. We need recovering people to pursue education and professional careers in the field in order to forge a new science of addiction recovery. We need collaborations between scientists and people in recovery to design, conduct, and interpret studies of long-term addiction recovery. We suspect that this movement has already begun. We hope you will be part of it.

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Acknowledgment: We would like to thank Jason Schwartz for several questions related to LSR that we've incorporated into this paper.

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Citation: Titus, J.C. & White, W.L. (2009). Substance use among youths with hearing loss: A primer for student assistance professionals. *Student Assistance Journal*, 20(3), 14-18. Posted at **www.williamwhitepapers.com**

Substance Use among Deaf and Hard of Hearing Youths: A Primer for Student Assistance Professionals

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Over the past 40 years, the number of deaf[1] and hard of hearing students educated in public school settings rather than in specialized schools for the Deaf has increased dramatically. Gallaudet University's Annual Survey of Deaf and Hard of Hearing Children and Youth reports that in the 2006-2007 school year, 64.8% of deaf and hard of hearing students were "mainstreamed" with hearing students at least 1 hour per week, with 43.9% mainstreamed for at least 16 hours per week. As a result, student assistance professionals are increasingly being called upon to respond to the special needs of deaf and hard of hearing students. These needs include responses to a wide spectrum of problems, including problems related to alcohol and other drug use.

This article 1) reviews the latest survey data on substance use among deaf and hard of hearing students, 2) summarizes the profile of students with hearing loss who are experiencing serious substance-related problems, 3) offers suggestions on what student assistance professionals can do to enhance their effectiveness working with substance-involved deaf and hard of hearing students, and 4) identifies key sources of information that may aid this helping process.

Hearing Loss and Substance Use Prevalence and Problems

Students who are hard of hearing constitute the majority of mainstreamed students with hearing loss. Although they have a certain degree of useable hearing, these students often do not fully understand spoken communication, even with the help of hearing aids. In contrast to hard of hearing students, deaf students are unable to use their hearing for communication purposes. In order to participate in regular education classrooms, deaf and hard of hearing students often depend on such support services as interpreters, preferential seating, and notetakers.

Research on the prevalence of alcohol and other drug use among deaf and hard of hearing youths is exceedingly scant and methodologically weak. For many years, substance-related problems among deaf people were characterized as "uncounted, unreached, untreated" (Boros, 1981). Existing studies paint an inconsistent picture, but most researchers agree that the

prevalence of alcohol and drug use among deaf and hard of hearing people is at least as prevalent as that among hearing people.

In addition to the usual risk factors found in the youth population, deaf and hard of hearing students face additional issues related to substance use. These factors include:

- limited family discussion and social learning about the dangers of drug use;
- decreased exposure to formal prevention programs, more so for deaf than hard of hearing youth;
- decreased access to family and extended family support (the majority of children with hearing loss have hearing parents, and not all families choose to learn or become proficient in sign language);
- disability-related effects on self-esteem and identity development;
- increased emotional distress related to social isolation and struggles to connect with a hearing world;
- enablement by the non-disabled population, resulting in a sense of entitlement to substance use because of disability-related limitations and estrangement from others; and
- a deep need to fit in with hearing and non-hearing peers, including students who use alcohol and other drugs (Dick, 1996; Gallaudet Research Institute, 2007; Guthmann & Sandberg, 1998; McCrone, 1982; Oliva, 2004).

These special risk factors seem to produce greater problem severity among deaf and hard of hearing students who go on to develop substance-related problems. This pattern is evident in the largest study to date of youths with hearing loss entering addiction treatment in the United States (Titus, Schiller, & Guthmann, 2008). In this study, deaf and hard of hearing youth and hearing youth shared many characteristics, but the former were found to be distinguished by six critical factors:

1. lower age of onset of substance use;
2. greater substance problem severity (dependence and withdrawal);
3. higher rates and greater severity of childhood victimization;
4. higher rates of co-occurring psychological problems (depression, traumatic stress, conduct problems);
5. social networks more dominated by substance users; and
6. greater likelihood of past running away from home or being homeless.

All of the above factors have been identified as obstacles to long-term recovery, suggesting that deaf and hard of hearing students who have substance problems may require treatment of greater intensity and post-treatment recovery support services of greater duration.

Assessment, Treatment and Recovery

Assessment and treatment of substance use disorders among youths and adults with hearing loss have not progressed much in recent decades. Report recommendations prepared in the 1970s and 1980s about the need for improved accessibility and quality of addiction treatment are as relevant today as when they were first written. Several specialized addiction treatment programs for deaf and hard of hearing people identified various issues that need to be addressed when providing services to this population. Adaptations of these recommendations as they apply to youths are as follows.

Assessment Students with stronger English literacy skills and less severe hearing losses may be able to complete a written or orally administered English language substance abuse

assessment with few to no accommodations. However, for students with severe to profound losses, an English language assessment may not be appropriate. The average reading comprehension of deaf 17 and 18 year olds is at the 4th grade level (Gallaudet Research Institute, 1996), and language used on substance abuse assessments can be more advanced than that. In this case, a signed assessment is required. There are numerous challenges to signed assessments, even when administered by qualified interpreters. First, there is only one signed alcohol/drug screening instrument[2] (Alexander, 2005) and no diagnostic instruments validated for deaf and hard of hearing people. In addition, the language of substance abuse is replete with English colloquialisms and concepts that do not have clear translations to sign language (e.g., "black out"). There is a fair amount of regional variability in signs for particular words (e.g., six signs for "hangover"). The Deaf community is small and members are well informed of what is going on in each others' lives, so confidentiality is at stake for students who have ties to this culture (Alexander, DiNitto & Tidblom, 2005; Guthmann, & Sandberg, 1998). Screening and assessment is best done in collaboration with persons possessing a knowledge of Deaf culture.

Resource Mobilization Young people with hearing loss in need of treatment for substance-related problems can find themselves trapped between three worlds—a school, an addiction treatment agency, and an agency serving the Deaf, all of whom feel they lack the expertise needed to address this combination of problems and circumstances. One of the roles the student assistance professional can serve in this situation is that of convener—bringing multiple agencies together to facilitate the assessment, treatment and long-term recovery support process.

Professional Treatment There are very few addiction treatment resources tailored specifically for deaf and hard of hearing individuals and only a handful of programs. Thus, most deaf and hard of hearing youths who could benefit from culturally and linguistically adapted treatment do not receive it. Deaf and hard of hearing youths are most often treated in hearing programs with the aid of interpreters, many of whom may not be sufficiently qualified to function effectively in addiction treatment settings. It is vitally important that hearing counselors who provide treatment to deaf and hard of hearing youths have a working knowledge of Deaf culture as well as an understanding of the impact a hearing loss can have on an individual who must function in a hearing world. There is some consensus that mainstreaming youths with hearing loss into addiction treatment may be more acceptable for those who experienced hearing loss later in life, possess some oral communication abilities, and do not strongly identify with Deaf culture (Guthmann & Graham, 2004). Thus far, there have been no randomized trials comparing the relative effectiveness of treating deaf and hard of hearing youths in a segregated program versus in a program with hearing youths.

In spite of the above-noted obstacles, research on post-treatment recovery rates of deaf and hard of hearing people are equivalent to those of their hearing peers (Moore & McAweeney, 2007). A study of a specialized addiction treatment unit for Deaf and hard of hearing youth and adults found that improved recovery outcomes were related to three factors: 1) attendance at recovery support groups such as Alcoholics Anonymous and Narcotics Anonymous, 2) having family members support sobriety efforts, and 3) being employed (Guthmann, 1996; Guthmann & Blozis, 2001).

Recovery Support Resources Integrating recovery into a sustainable lifestyle is a particular challenge for deaf and hard of hearing people of any age. The community of people with hearing loss is small, and existing substance-focused relationships may be the only significant social relationships in the individual's life. Hearing loss may pose obstacles to developing recovery supports in the hearing community, and recovery-focused role models and relationships among other deaf people may be non-existent or limited (Rendon, 1992). Few options exist for culturally and linguistically accessible recovery resources, especially for youths. A notable exception can be found in some larger communities, where Deaf-run recovery groups such as Alcoholics Anonymous operate. Some hearing recovery groups have interpreter support, though the cost of an interpreter can be a barrier. Internet-based recovery communities provide a source of

support for deaf and hard of hearing individuals with adequate English skills. Some recovery homes accept deaf adult clients and several sign language recovery homes have been established. A recent evaluation of an Oxford House recovery home found it to be an effective alternative for deaf individuals seeking support for recovery (Alvarez, Adebanjo, Davidson, et al, 2006). These resources may prevent post-treatment isolation and lower the risk of relapse in encounters with prior relationships based on substance use. Options specifically targeted to youths, though, are lacking.

Prescriptions for Student Assistance Professionals

Given this review of what we know about substance-related problems among deaf and hard of hearing students, how can the student assistance professional respond to the needs of these students? We propose the following nine suggestions:

1. Remain aware of how hearing-loss-related issues may present themselves, e.g., isolation, wanting to fit in with hearing peers, attempts at "passing," impaired parent-child communication, low self-esteem, and entitlement to excessive behavior.
2. Learn as much as you can about Deaf culture and the variations in how people with hearing loss relate to Deaf culture.
3. Seek consultation with agencies servicing individuals with hearing loss and agencies for the Deaf.
4. Identify local/regional resources for substance-involved students who are deaf or hard of hearing.
5. Learn how to collaborate with qualified interpreters, e.g. speaking to the student rather than the interpreter, establishing confidentiality guidelines, debriefing.
6. Create an acoustical environment conducive to communication with hard of hearing students, e.g., provide enhanced lighting, minimize background noise and visual distractions, remain facing the student when speaking, maintain eye contact, enunciate each word clearly, avoid covering your mouth with your hand.
7. Capitalize on prevention and early intervention opportunities with deaf or hard of hearing students that focus on information dissemination and issues of social isolation, adjustment to hearing loss, and family distress.
8. Link students with serious substance use problems to specialized resources for assessment, treatment, and peer-based recovery support using assertive linkage procedures, e.g., physically linking the student to the resources versus providing a name and verbal encouragement to go.
9. Conduct on-going recovery check-ups either at regular intervals or at times identified to be particularly high risk for relapse.

Suggested Reading, Resources, and Websites

- 12 steps recovery resources for deaf and hard of hearing individuals - http://www.dhh12s.com/accessdeafhoh.htm
- Chestnut Health Systems' list of addiction treatment resources for people with hearing loss - http://www.chestnut.org/LI/APSS/Common/Multicultural/D-HH_Resources.pdf
- Communication tips for working with deaf and hard of hearing individuals - http://www.michdhh.org/hearing/comm_tips.html
- Communication tips for working with sign language interpreters – http://www.sfgov.org/site/mod_page.asp?id=42215
- Curriculum package on substance abuse in the Deaf and hard of hearing community available through the mid-Atlantic ATTC - http://www.mid-attc.org/order%20forms/ProductOrderForm4_2_08.doc (inactive link)

- Gina Oliva's book on isolation among hard of hearing children in the mainstream - Oliva, G. (2004). *Alone in the Mainstream*. Washington, D.C.: Gallaudet University Press.
- List of resources on mainstreaming children with hearing loss – http://deafness.about.com/go/dynamic/offsite.htm?zi=1/XJ&sdn=deafness&cdn=health&tm=45&gps=153_866_1020_558&f=22&su=p726.2.152.ip_p284.8.150.ip_&tt=2&bt=0&bts=0&zu=http%3A//clerccenter.gallaudet.edu/InfoToGo/096.html (inactive link)
- Marc Marschark's comprehensive book on deaf children – Marschark, M. (1998). *Raising and educating a deaf child*. New York: Oxford University Press.
- Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals – www.mncddeaf.org
- National Clearinghouse Catalog – Addressing the Chemical Health Needs of Deaf and Hard of Hearing Individuals - http://www.mncddeaf.org/pages/clearinghouse_catalog.pdf
- National Directory of Alcohol and Other Drugs Prevention and Treatment Programs Accessible to the Deaf - http://www.rit.edu/studentaffairs/counseling/saisd/national_directory/nat.directory.htm
- Northwest Deaf Addiction Center - http://www.lifelineconnections.org/home/dac.shtml
- Videos, workbooks, and DVDs for use with deaf and hard of hearing substance abusers, including an anti-tobacco curriculum aimed at teens - http://www.mncddeaf.org/pages/materials.htm

Footnotes

[1] It is customary when referring to people with hearing loss to distinguish between the terms "deaf" and "Deaf". Although subtly different in appearance, their connotations reflect two very different world views of what it means to have a hearing loss. The term "deaf" describes an audiological hearing loss and is associated with the medical model of deafness, which views hearing loss as a disability. The term "Deaf" is associated with the cultural model of deafness, which views deaf people as a language minority – a community of people with a shared language, history, social norms, traditions, and values who happen to not hear. Those who provide services to people with hearing loss are advised to be aware of the difference between these terms and anticipate how one's identification as deaf or Deaf could interact with service provision.

[2] Efforts are currently underway to create a second substance abuse screening instrument that is validated and normed on a Deaf and hard of hearing population. The Substance Abuse in Vocational Rehabilitation-Screener in American Sign Language (SAVRS-S-ASL; Guthmann & Moore, 2007) is an ASL translation of the Substance Abuse Subtle Screening Inventory (3rd edition) (SASSI-3; Miller, Roberts, Brooks, & Lazowski, 1997). The project is being led by Dr. Debra Guthmann of the California School for the Deaf –Fremont and Dr. Dennis Moore of Wright State University.

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Acknowledgments

The authors wish to thank Dr. Debra Guthmann of the California School for the Deaf-Fremont and Mr. James Schiller of Gallaudet University in Washington, D.C. for their review and comments on the preliminary draft of this article.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2010) Commentary: AA, alcoholism recovery, global health and quality of life. *Addiction*, 105, 637-638. Posted at **www.williamwhitepapers.com**

AA, Alcoholism Recovery, Global Health and Quality of Life

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Scientific studies to evaluate the effectiveness of Alcoholics Anonymous have significantly increased in number and methodological sophistication. [1] Early AA studies focused narrowly on drinking outcomes, but more recent studies reflect growing interest in the effects of AA participation on the larger arenas of emotional/behavioral health and quality of life. [2-4] Current efforts to define recovery for research and clinical purposes similarly include the elements of global health and citizenship in addition to the resolution of alcohol and other drug problems. [5] These trends are congruent with AA's view of itself. A central tenet of AA is that recovery from alcoholism involves far more than the removal of alcohol from an otherwise unchanged life. AA's Twelve Steps and core concepts within the culture of AA (e.g., *dry drunk*, *emotional sobriety*, *spiritual awakening*) convey a vision of recovery as a radical transformation in character, identity, and interpersonal relationships. AA's "promises" speak not of an escape from drunkenness but from fear, selfishness, self-pity, and regret and the acquisition of freedom, happiness, serenity, peace, confidence, and authentic connection to others. [6]

Kelly, Stout, Magill, Tonigan, and Pagano [7] have added to the literature of the effects of AA on global health through their study of changes in depression as a mediator of the influence of AA participation on drinking outcomes. The authors begin with two foundational points: 1) depression can predate the onset of alcohol use disorders (AUD), be exacerbated by AUD, or emerge as a consequence of AUD, and 2) depression constitutes an obstacle to recovery and a risk factor for relapse following recovery initiation. Kelly and colleagues' finding that AA participation alters drinking patterns (via increased abstinence and lowered intensity and duration of relapse episodes), in part, by decreasing negative affect and depression adds an important new contribution to the existing literature on mechanisms of change in AA. They also add nuance to the question of whether factors such as decreased depression are peripheral outcomes of changes in drinking behavior or the driving force behind changes in drinking behavior. The lagged design of this study allows a clearer suggestion of causation related to the latter influence. Hopefully, future studies of mechanisms of change in AA will similarly

distinguish mediators of change from outcomes of change.

If the study by Kelly and colleagues were to stand as a historical artifact of early twenty-first century research on AA and recovery from AUD, that artifact would suggest several important findings. It would tell us that AA has survived and thrived as it approaches its 75th birthday—an important finding given that few of its predecessors outlived their founding generation. [8] The finding that AA's Twelve Step program can alter a targeted behavior and simultaneously or sequentially enhance global health and quality of life offers an important clue to AA's growth to more than two million members, its worldwide dispersion, and the seemingly endless adaptation of AA's program to other problems of living. The Kelly et al. study also stands as a testament to our deepening understanding of the recovery process and a symbol of the coming of age of methodological rigor in the scientific study of mutual aid groups.

Research on the resolution of alcohol and other drug problems has traditionally focused on a process of subtraction—the problems that are diminished or eliminated through the recovery process. The Kelly et al. study is indicative of a new focus: the measurement of what recovery adds to the lives of individuals, families, and communities. That shift in focus is long overdue, and its fruits could help alter the social and professional stigma that continues to be attached to alcohol and other drug use disorders.

Scientific knowledge and experiential knowledge represent two radically different traditions of knowing, [9] yet scientists and AA members are finding common ground as both groups try to more deeply understand how AA works and seek to widen the doorway of entry into long-term recovery from severe alcohol-related problems. Science can pose both threats and opportunities to recovery mutual aid societies, but there seems little question that we are entering an era of confluence between key elements of AA folklore and the findings of rigorous scientific studies.

Key Words: Alcoholics Anonymous, alcohol dependence**,** depression, mechanisms of change, global health, quality of life

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Citation: White, W. & Lindsey, R. (2010). Alcoholism, the family, and the limits of love: A biography of hope and healing. Accessed April 23, 2010 at http://psychcentral.com/blog/archives/2010/04/22/alcoholism-family-and-the-limits-of-love/
Posted at **www.williamwhitepapers.com**

Alcoholism, the Family, and the Limits of Love: A Biography of Hope and Healing

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On April 25th, Hallmark Hall of Fame will broadcast the movie "When Love Is Not Enough—The Lois Wilson Story," starring Winona Ryder and Barry Pepper (CBS, 8 pm CT, 9 pm ET). The movie, which portrays the life of Lois Wilson, co-founder of Al-Anon and wife of Alcoholics Anonymous (AA) co-founder Bill Wilson, is based on William G. Borchert's 2005 book, *The Lois Wilson Story: When Love Is Not Enough*. Borchert's earlier screenplay was the basis of the acclaimed movie My Name is Bill W., starring James Woods, James Garner, and JoBeth Williams. The premiere of the movie falls during the National Council on Alcoholism and Drug Dependence, Inc.'s (NCADD) 24th Annual Alcohol Awareness Month with its theme, "When Love Is Not Enough: Helping Families Coping With Alcoholism."

Lois Wilson fell in love with a man whose alcoholism brought his life and their relationship to the brink before he began his personal recovery and helped found Alcoholics Anonymous. Lois and many of the other wives of early AA members also began to band together for mutual support, formalizing these meetings into Al-Anon Family Groups in 1951. *When Love is Not Enough* is the story of Lois Wilson and her life with Bill Wilson. The reach of her and their stories is unfathomable and inseparable from the larger stories of AA and Al-Anon and the influence their lives would exert on the larger story of the professional treatment and recovery of individuals and families affected by addiction to alcohol and other drugs. As William Borchert suggests:

"In the end, Bill Wilson's alcoholism proved not to be the tragic undoing of this brilliant and loving couple, but rather the beginning of two of the twentieth century's most important social and spiritual movements-Alcoholics Anonymous and Al-Anon Family Groups."

There are presently more than 114,500 Alcoholics Anonymous groups (with a combined membership of more than 2

million) and more than 25,000 Al-Anon/Alateen groups (with a combined membership of more than 340,000) hosting local meetings worldwide.

When Love is Not Enough is clearly more than a love story, though it is surely that. Readers of *Psych Central* and the people they serve will discover in this movie six profound lessons about the impact of alcoholism and alcoholism recovery on intimate relationships and the family.

1. Prolonged cultural misunderstandings about the nature of alcoholism have left a legacy of family shame and secrecy. Centuries of debates between those advocating religious, moral, criminal, psychiatric, psychological, medical, and sociological theories of alcoholism failed to offer clear guidance to individuals and families affected by alcoholism. *When Love is Not Enough* is in part a poignant history of the hidden desperation many families experienced before the birth of Alcoholics Anonymous, Al-Anon, and modern alcoholism treatment. Lois Wilson and Anne Bingham helped change that history in 1951 when they organized 87 groups of wives of AA members into the Al-Anon Family Groups.
2. Alcoholism is a family disease in the sense that it also wounds those closest to the alcohol dependent person; transforms family relationships, roles, rules, and rituals; and isolates the family from potential sources of extended family, social, and community support. And, it has far reaching, long-lasting effects on the physical and emotional health of the family and children. *When Love is Not Enough* conveys the physical and emotional distress of those struggling to understand a loved one who has lost control of drinking and its consequences. It vividly portrays the disappointment, confusion, frustration, anger, resentment, jealousy, fear, guilt, shame, anxiety, and depression family members experience in the face of alcoholism. The recognition that significant others and their children become as sick as the person addicted and are in need of a parallel pathway of recovery were the seeds from which Al-Anon and Alateen grew.
3. The family experience of alcoholism is often one of extreme duality. *When Love is Not Enough* poignantly conveys this duality: brief hope-inspiring interludes of abstinence or moderated drinking, periods of peacefulness, moments of love and shared dreams for the future—all relentlessly violated by explosive bouts of drinking and their devastating aftereffects. Memories of that lost person and those moments and dreams co-exist even in the face of the worst effects of alcoholism on the family. It is only in recognizing this duality of experience and the character duality of the alcoholic that one can answer the enigmatic question that is so often posed about Lois Wilson's contemporary counterparts, "Why does she/he stay with him/her?" As clinicians, we can too often forget that these family stories contain much more than the pathology of alcohol or drug dependence (White, 2006).
4. Family recovery from alcoholism is a turbulent, threatening, and life-changing experience. The hope of all families and children wounded by alcoholism is that the drinking will stop and with it, the arrival of an idyllic family life. Lois Wilson's story confirms what research on family recovery from addiction is revealing: recovery from alcoholism can destabilize intimate and family relationships. Stephanie Brown and Virginia Lewis (1999), in their studies of the impact of alcoholism recovery on the family, speak of this as the "trauma of recovery." People recovering from alcoholism, their families, and their children can and often do achieve optimum levels of health and functioning, but this achievement is best measured in years rather than days, weeks, or months. That recognition in the life of Lois Wilson underscored the need for sustained support for families as they went through this process.
5. We cannot change another person, only ourselves. If there is a central, singular message from Lois Wilson's life

and from the Al-Anon program, this may well be it. Al-Anon's defining moments came when family members stopped focusing on how they could change and control their addicted family member and focused instead on their own need for regeneration and spiritual growth, the overall health of their families, and the comfort and help they could offer each other and other families similarly affected. Their further discovery that AA's twelve step program of recovery could also guide the healing of family members marks the birth of the modern conceptualization of family recovery. The 2009 Al-Anon Membership Survey confirms the wide and enduring benefits members report experiencing as a result of their sustained involvement in Al-Anon—irrespective of the drinking status of their family members.

6. The wonder of family recovery. As a direct result of Lois's groundbreaking work in co-founding Al-Anon and the impact it has had on the field of alcohol and drug treatment, family recovery from alcoholism is a reality for millions of Americans today, and the hope, help, and healing of family recovery has become the most powerful way to break the intergenerational cycle of alcoholism and addiction in the family.

The growing interest in the lives of Bill and Lois Wilson—as indicated by a stream of memoirs, biographies, plays, and films—is testimony to the contributions that Alcoholics Anonymous and Al-Anon Family Groups have made to personal and family recovery from alcoholism and to the ever-widening adaptation of the Twelve Steps to other problems of living (Wilson, 1994). Psych Central readers will find much of value in *When Love Is Not Enough—The Lois Wilson Story*, including the power of Al-Anon as a tool of support for clients living with someone else's alcoholism. A DVD of the movie and a Viewer's Guide, for use as a tool in family and community education, will be available at www.hallmarkhalloffame.com on April 25th, the day of the movie's premiere.

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Resources

Al-Anon Family Group Headquarters, Inc., www.al-anonfamilygroups.org, 800-4AL-ANON (888-425-2666), Monday-Friday, 8 a.m. to 6 p.m., ET.

Alcoholics Anonymous, www.aa.org.

National Council on Alcoholism and Drug Dependence, Inc. (NCADD), www.ncadd.org, 212-269-7797.



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Citation: White, W., Evans, A.C. & Lamb, R. (2010). Community recovery.
Posted at www.williamwhitepapers.com and www.facesandvoicesofrecovery.com

Community Recovery

William L. White, M.A., Arthur C. Evans, Jr, Ph.D., and Roland Lamb, M.A.

Abstract

The concept of recovery within the addictions arena has most often been applied to the personal resolution of severe alcohol and other drug (AOD) problems. The emergence of the concept of family recovery suggests that social systems beyond the individual can be wounded by and experience recovery from the effects of AOD and related problems. This paper defines community recovery, posits a set of preliminary principles related to community recovery, presents a case study of community recovery, and outlines strategies used in the City of Philadelphia that are promoting processes of community recovery.

Introduction

Recovery is emerging as a central organizing concept for the transformation of addiction treatment and the broader arena of behavioral health care in the United States (Evans, 2007; Evans & Beigel, 2006; White, 2005, 2008a,b). Recent efforts to more precisely define recovery have emphasized reconstruction of relationship to community as a central element of the recovery experience. The Betty Ford Institute Consensus Panel (2007) characterized this reconstruction as “citizenship,” and the UK Drug Policy Commission Recovery Consensus Group (2008) described it as “participation in the rights, roles and responsibilities of society.” White (2007a), drawing on the broader conceptualization of recovery within Native American (Coyhis & White, 2006) and African American (White & Sanders, 2008) communities, subsequently depicted recovery as a healing process that could move beyond individuals and families to encompass whole communities, as graphically depicted below.

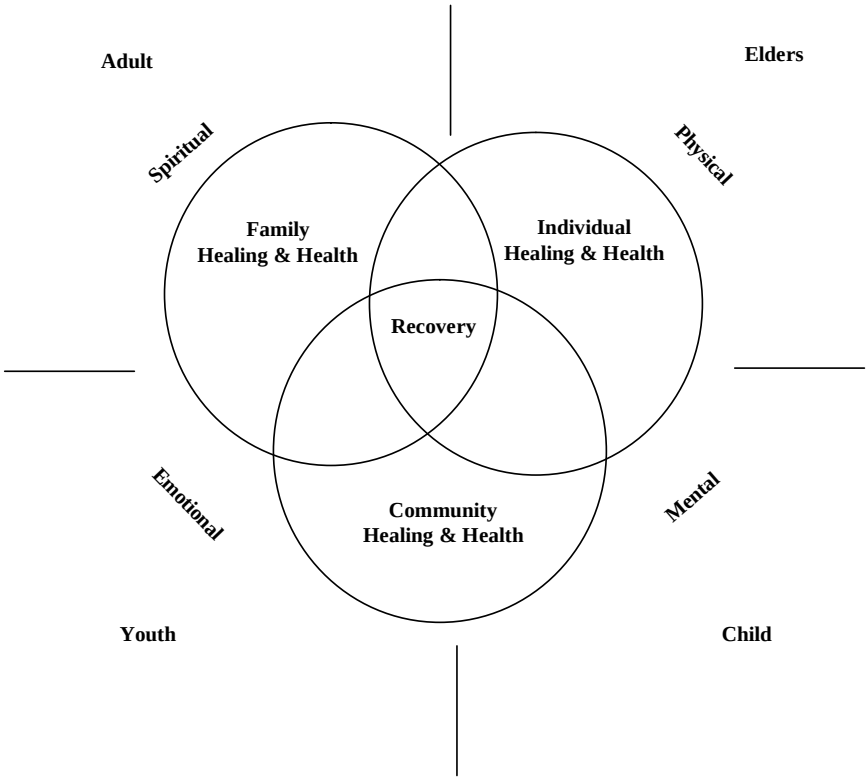

Figure 1: Recovery and the Life Cycle of the Individual, the Family, the Community
Source: Charlene Belleau, Former Chief, Alkali Lake Band of Indians (White, 2007a, p. 237)

While a process of community recovery was suggested in this early article, the concept of community recovery was not defined or amplified. The purpose of this article is to draw on the authors' experience with a recovery-focused systems transformation process within the City of Philadelphia to define community recovery and outline some working principles related to community recovery.

The Ecology of AOD Problems

Communities as well as individuals and families can be wounded by severe and prolonged alcohol and other drug (AOD) problems. Widespread, excessive AOD problems erode sources of community resilience (e.g., strong families, close kinship networks, vibrant indigenous community institutions) and spawn collateral problems and conditions that further fuel AOD use and its escalating personal and community consequences. This self-perpetuating, accelerating cycle can be graphically depicted as follows.

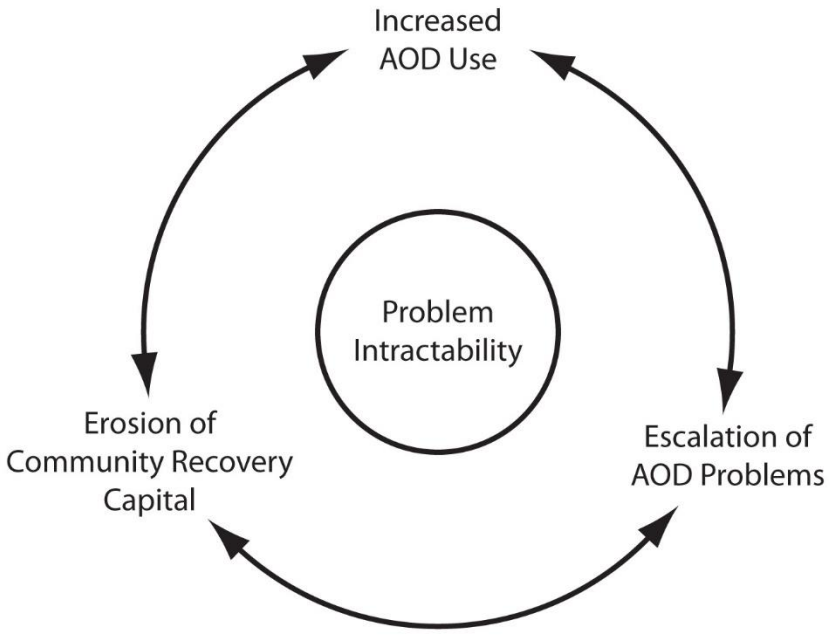

Figure 2: Problem Intractability and Personal/Community Demoralization

The etiology of AOD problems has in recent decades been portrayed within two organizing lenses, the first defining the problem as one of personal vulnerability (a genetically influenced disease process warranting medical treatment), and the second defining the problem as one of personal culpability (a moral or characterological problem warranting punishment and control). However, as the above figures suggest, there are contextual influences at a community level that profoundly influence the prevalence, course, and consequences of AOD problems. These contextual influences constitute the soil in which AOD problems flourish or are squelched at personal, family, and community levels. These influences also determine whether severe AOD problems are intractable or amenable to prevention, early intervention, treatment, and recovery support interventions.

Communities can experience three levels of strain that influence the prevalence of AOD problems. The first is the normal stress that all communities experience in response to internal and external changes. Most communities have the internal resources to respond to these stressors, and AOD problems in such communities are limited to a small percentage of community members who possess a particular vulnerability for AOD-related problems.

A second form of strain is distress—demands for community adaptation that exceed the collective coping capacity of community members. Such distress can occur in the face of natural disaster, loss of economic infrastructure, or extreme social disruption, cresting in a “tipping point” in the prevalence of personal/social problems. Under these circumstances, personal, family, and community deterioration unfolds and interacts synergistically to rapidly increase prevalence and severity of AOD problems. These problems and their connectors (e.g., family dissolution, child abuse/neglect, homelessness, crime, violence, infectious disease) become shrouded in an aura of intractability that spreads a contagion of frustration, hopelessness, apathy, and resignation or triggers aggression (shunning, scapegoating, punishment, community extrusion) aimed at, affected by, or viewed as the source of these problems.

A third form of community strain is that of historical trauma—a unique form of distress created by the physical or cultural assault on a people via attempted genocide or sustained colonization. Such trauma erodes indigenous sources of cultural and personal resilience and heightens vulnerability to a wide spectrum of personal and social problems. What is distinctive about historical trauma is the propensity for its effects to be transmitted intergenerationally over extremely prolonged periods of time (Brave Heart & DeBruyn, 1998). When historical trauma and contemporary distress align, communities, community institutions, neighborhoods, families, and individuals become particularly vulnerable to AOD problems (Brave Heart, 2003; Morgan, 1983). Over time, learned helplessness and hopelessness in the face of such problems can become part of the community culture absorbed across generations.

Alcohol and other drugs serve multiple functions in distressed and historically traumatized communities. They serve as a balm for emotional distress, an escape from feelings of powerlessness, and a trigger and excuse for the discharge of anger (Douglass, 1855). They serve as symbols of cultural protest (Lurie, 1974). They serve as the centerpieces of subcultures within which those most disconnected from mainstream community life find mutual support (White, 1996). They spawn underground economies and careers (Waldorf, 1973). They serve as instruments of financial exploitation by predatory industries, and they serve as tools of personal and cultural pacification (Douglass, 1855; Hacker, Collins, & Jacobson, 1987; Morgan, 1983).

Several propositions drawn from sociological and psychological studies can guide our shift in focus from the community context of AOD problems to community-level recovery processes. Among the most important of these propositions are the following:

- Weakened family, kinship network, neighborhood, and natural community ties create an environment in which personal and social problems flourish (Bellah, Madsen, Sullivan, et al., 1985).
- Weakened family, kinship network, neighborhood, and natural community ties diminish personal and collective capacities to respond to distress and trauma (Bloom, 1997).
- Resurging and new social structures (e.g., gangs, mutual aid groups, cell phone and internet-based social networking) are meeting support functions once met by traditional social institutions (e.g., churches, schools, workplaces, civic organizations) (White, 2002).
- The industrialization and commercialization of personal compassion (via ever-growing health and social services agencies) and social control (via ever-growing police, courts, correctional agencies, child protection agencies) may have inadvertently hastened the dissolution of family, kinship, neighborhood, and community ties (McKnight, 1995).
- “We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery” (Bloom, 1997, p. 117).

Strategies of community development and renewal (embraced here within the conceptual rubric of community recovery) can compliment and, in some cases, stand as an alternative to clinical models of intervention into AOD problems. There are pilots of community-level recovery resource development and mobilization from the 1960s and 1970s that could be refined and redeployed on a large scale to enhance the healing of individuals, families, and whole communities (Mulford, 1976, 1978; White, 2002, 2003). Such strategies reflect the Native American belief that “…the individual, family and community are not separate; they are one. To injure one is to injure all; to heal one is to heal all” (*Red Road to Wellbriety*, 2002, p. f).

Community Recovery: Definition and Principles

A neighborhood, community, or culture can be said to be in need of recovery when AOD-related problems reach a level of prevalence and severity that threatens collective health and functioning. In short, systems can become impaired by addiction and the broader arena of AOD problems, and they

can reach a level of such impairment that threatens their future vitality and existence. The need for recovery at a community level could be quantified using a broad spectrum of epidemiological data (e.g., AOD-linked data related to death, disability, disease, quality of family and neighborhood life, etc.) that is currently collected on a routine basis by a mix of federal, state, and local agencies.

Community recovery is a voluntary process through which a community uses the assertive resolution of AOD-related problems as a vehicle for collective healing, community renewal, and enhanced intergenerational resilience. Community recovery is more than the personal recovery of community members; it involves strengthening the connective tissue between those with and without such problems while restoring and sustaining the quality of community life.

Community recovery is *voluntary* in the sense that it involves a rising community consciousness (acknowledgement and clear definition of problems), community commitment, and community action. These three critical steps must rise from within the community and cannot be externally imposed. The stages of community recovery parallel the stages of personal and family recovery: 1) recovery priming (experiencing— suddenly or incrementally—a catalyst for change), 2) initiating a process of healing and renewal, 3) achieving sustained changes in community relationships, roles, rules, and rituals, and 4) enhancing the long-term health and quality of life within major community institutions and the community as a whole.

Community recovery is a *process* in the sense that it must unfold and be sustained in a prolonged if not permanent manner. It is not an event or one of a series of special projects. The factors that sustain community recovery are often different than the factors that initiate community recovery. The ultimate test of the community recovery process is not the mass recovery of one generation, but breaking intergenerational cycles of problem transmission and imbedding personal, family, and cultural resistance and resilience as an enduring intergenerational legacy within the deepest fabric of a community.

Community recovery is *assertive* in the sense that the diminishment of AOD and broader problems occurs as a result of concerted, collective action rather than a process of attritional drift (via the maturing, extrusion, or death of those community members with severe AOD problems).

The *resolution* of AOD-related problems reflects a broad spectrum of outcomes across neighborhoods, families, and individuals. These outcomes include the complete cessation of AOD use, reduction of AOD use to non-problematic levels, reduction of patterns of AOD use that pose the greatest threats to public health and safety, and the reduction of peripheral effects of AOD use on families and neighborhoods. The resolution aspect of recovery is measured by what is subtracted from family and community life.

Collective healing, renewal, and resilience are aspects of recovery measured by what is added to family and community life. These outcomes include the enhanced health of individuals; the repair of strained or severed relationships within the community; the renewal and rise of indigenous leaders; the enhanced health of key community institutions; intergenerational connectivity; and the enhanced resilience of individuals (particularly children, adolescents, and transition age youth), families, and neighborhoods.

The *prognosis for community recovery* is influenced by the ratio of problem prevalence, severity, and complexity to the level of community recovery capital. *Community recovery capital* encompasses the scope and quality of resources that can be mobilized to initiate and sustain a community recovery and revitalization process. People in personal/family recovery are an important source of recovery capital that can be mobilized to serve as recovery carriers in their daily interactions within the community. With rising recovery capital, push forces out of addiction (experienced and feared pain and consequences of AOD use) become balanced with pull forces for addiction recovery (attraction to the promises of recovery as exemplified in the lives of recovery carriers) (White, 2010).

There are *multiple pathways and styles of community recovery and renewal*. Successful strategies and tactics for community recovery and renewal must achieve a community/cultural fit. Each family/neighborhood/community must find personally and culturally meaningful metaphors that help them reconstruct a new recovery-based community identity (story) within which four questions are answered:

- Who and what were we before these problems peaked?
- What happened to us as a result of these problems?
- What sparked the recovery process?
- Who and what are we now and who and what are we becoming?

Sustainable community recovery engages multiple community institutions: government, business, and industry; civic and neighborhood organizations; health and social service agencies; educational institutions; the criminal justice system; religious institutions; sports and leisure institutions; and the arts community. The catalyst for community recovery can come from any one of these sectors, but the long-term prognosis for recovery and community renewal is enhanced when multiple sectors are involved.

Community recovery can be measured in terms of reduction of pathology, but is best measured in terms of long-term increases in recovery capital, e.g., increases in recovery prevalence, pro-recovery community policies, recovery support resources (mutual aid groups, recovery community organizations, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-identified sport and leisure activities, etc.).

Community recovery diminishes the necessity of personal and family recovery by lowering personal/family vulnerability and heightening personal/family resilience.

Community recovery elevates the prognosis for personal/family recovery by elevating external recovery capital and creating the physical, psychological, and cultural space where recovery can flourish.

A Brief Case Study in Community Recovery[1]

No community response to alcohol problems has garnered more public and professional notice than that of the community of Alkali Lake, British Columbia. The Shuswap tribal community in Alkali Lake was so plagued with alcohol problems that surrounding communities referred to it as "Alcohol Lake." The change began in 1971 when Phyllis and Andy Chelsea made a commitment to stop drinking and to confront the pervasive alcohol problems within their community. When Andy Chelsea was subsequently elected Chief of the Shuswap Tribe, he began promoting AA meetings, arresting bootleggers (including his own mother), confronting the drunkenness of public officials, and staging interventions to get community members into treatment. Tribal traditions were revitalized for both the adults and children of the community. Educational and job development programs were initiated for those in recovery. Over a period of ten years, this sustained effort reduced the prevalence of alcohol problems from nearly 100 percent of the tribe to less than 5 percent (Ben, 1991; Chelsea & Chelsea, 1985; Taylor, 1987). Community recovery is not a story with a beginning, middle, and end; it is an enduring process, and that process continues today in Alkali Lake (Haggerson, in press).

The story of the revitalization of Alakli Lake was captured in a documentary film, *The Honour of All*, directed by Canadian filmmaker Phil Lucas. The film inspired, and continues to inspire, sobriety-based cultural revitalization movements among indigenous peoples throughout the world (Ben, 1991). The proclamation of Chief Andy Chelsea that "the community is the treatment center" (quoted in Abbot, 1998) illustrates a collectivist, as opposed to individualistic, approach to the resolution of alcohol problems. As noted earlier, Native frameworks of recovery have always been, and continue to be, framed in terms of an inextricable link between hope for the individual and hope for a community and a people (*The Red Road to Wellbriety,* 2002). This theme is very evident in the contemporary Native American Wellbriety movement (Coyhis & White, 2006).

Notes from Philadelphia

[1] This case study is excerpted from Coyhis and White, 2006.

For the past five years, the authors have been involved with the Philadelphia Department of Behavioral Health's efforts to transform Philadelphia's network of behavioral health organizations into a "recovery-oriented system of care" (See Achara-Abrahams, Evans & Kenerson King, in press; Lamb, Evans & White, 2009; White, 2007b). As the "systems transformation" unfolded around the values of recovery, resilience, and self-determination, the vision of the "system" changed from a narrow focus on behavioral health service providers to transformation of the larger community. Through this process the inextricable link between personal, family, neighborhood, and community health became ever clearer, and we began to include the idea of community recovery within discussions of the systems transformation process. While concerted focus remained on enhanced recovery outcomes for individuals and families affected by behavioral health disorders, we regularly revisited this idea of community recovery as both a goal and method.

Through this history, several strategies emerged that promoted recovery at these multiple levels. Some of these methods that we now see as most linked to the goal of community recovery are illustrated in the following table.

Table 1: Philadelphia-Inspired Strategies to Promote Community Recovery

Goals	Strategies	Rationale
Listen and engage	Conducting ongoing focus groups, town meetings, and other listening forums; eliciting personal, family, and community stories in settings where people can share their personal and collective "experience, strength and hope."	People in distressed communities need opportunities to share their struggles and experience being heard and understood. Healing can occur by seeing one's personal story as part of a larger story—movement from an "I" story to a "We" story.
Open closed systems	Hosting meetings that mix treatment providers, allied professionals, individuals and family members in recovery, and grassroots community organizations; creating structured exercises in relationship-building to decrease polarization; facilitating (inreach and outreach) relationships with larger community.	Distress breeds isolation and "us versus them" thinking; closed systems open only via increased boundary transactions and cross-boundary relationships.
Forge or strengthen partnerships	Desiloization: experiments in co-location; pushing integrated solutions to entangled problems; creating win-win outcomes for collaboration; cross-funding initiatives.	Distressed communities suffer from problem synergy—each problem magnifying and rendering more intractable other related problems, e.g., addiction, crime, violence, homelessness, child abuse/neglect, jail overcrowding, spread of infectious diseases, etc.

Create amplified and synergistic effects through integrated and linked projects	Funding recovery support services within non-traditional settings; experimenting with co-location and multi-agency teams	Community recovery requires decreasing distance between the location of problems and the location of solution-based resources, e.g., building recovery capital within neighborhoods and communities.
Strengthen natural supports[2]	Supporting grass roots efforts that provide support to the broader community; developing faith-based initiatives related to substance use prevention and persona/family recovery support; increasing collaboration between grassroots organizations and treatment providers through the development of community coalitions; seeding the development of activities that promote health and wellness through mini-grants to community based organizations	The most viable long-term recovery support is within relationships that are natural, non-hierarchical, non-professionalized, non-commercialized and sustained. The first-line of recovery support is the community; professional treatment is the safety net.
Promote tolerance, respect, and mutual support	Increasing contact between people affected by different challenges and between such individuals and members of the larger community; stigma committee strategy development.	Intolerance, stigma, and intergroup conflict are symptoms of community distress.
Inspire hope	Hosting recovery celebration events and recovery conferences; sponsoring recovery mural projects in the community; importing and developing charismatic speakers on addiction recovery.	Recovery initiation hinges on changing prevailing pessimism—elevating the idea that personal, family, and community recovery is possible and a growing reality. People who were once part of the problem can be transformed and mobilized as part of the solution.
Mobilize internal resources	Sponsoring storyteller training for people in recovery and families; identifying and engaging recovery community leaders; providing peer leadership training; increasing representation of recovering people within paid and volunteer roles; creating the Recovery Advisory Committee, Office of Addiction Services	Community recovery initiation is enhanced by mobilizing internal recovery capital. Community service is a vehicle of personal and community healing.

[2] We wish to acknowledge Dr. Ijeoma Achara for suggesting inclusion of natural supports in this table.

	Advisory Board, and multiple time-limited task forces.	
Mobilize external resources	Increasing procurement of federal and private grants to increase system resources (part of win-win strategy).	Community recovery initiation is enhanced by mobilizing external recovery capital.
Create a vision	Creating and disseminating Recovery Transformation Blueprint and Office of Addiction Services Strategic Plans.	Diminished attention span is a major indicator of community distress; community recovery requires a vision and vehicles to sustain commitment and focus: over-communicating and using every event to generate “legs” (systematic follow-up to achieve enduring effects).
Increase trust	Maintaining continuity of contact and commitment over time; assuring transparency in all decision-making; keeping promises; when wrong, promptly admitting it.	Exploitation and abandonment is the norm in distressed communities; community engagement requires a period of testing, trust building, and continuity of presence over time.
Over-communicate the vision, core ideas, and values	Providing centralized training of all stakeholders and recovery community to launch transformation process; Recovery Foundations Training for everyone in care system; using multiple media to convey vision and invite participation: papers and monographs, trainings, meetings, newsletters, newspapers, television, radio, video; involving indigenous leaders as message carriers.	Diversity of communication strategies must reflect knowledge of culturally-mediated learning styles. Repetition of communication over time and consistency of communication is needed to convey continuity of commitment to the community and key relationships within the continuity.
Provide Tools	Developing and disseminating science to practice papers, Tools for Transformation Series (checklists and promising practices), and Practice Guidelines.	Professional treatment should be the last, not the first, line of response to AOD problems. The front-line response to prevent and respond to these problems is the natural community itself.
Provide increased social space for recovery	Funding of Recovery Community Centers; providing people in recovery opportunities for community service; building recovery support into other community settings, schools, churches, businesses, arts, sports, etc.	Paying back (amends) and giving back (service) elevate the quality of long-term personal/family/community recovery.

Closing Reflections: Addiction Treatment and Community Recovery

As cultural commitment rose in the 1960s to take action on the country's growing alcohol and other drug problems, two models of intervention were proposed.

One model called for training consultants to mobilize local community resources to support long-term addiction recovery. The essential skills were those of community mobilization and development and brokering connections between individuals and families in need and indigenous recovery support resources. Those resources could include professional assistance in recovery initiation, but the emphasis was on support that was voluntary, reciprocal, enduring, and non-commercialized (Mulford, 1976, 1978; White, 2002, 2003). This approach mobilized community resources to support individual and family recovery but stopped short of conceptualizing a recovery process for the community as a whole.

A second approach, a medical model, relied on the development of specialized treatment facilities within which trained professionals would screen, assess, diagnose, and treat individuals and families impacted by severe alcohol and other drug problems. That approach, which laid the foundation for the modern addiction treatment industry, defined the source and solutions to addiction at the microsystem level (individual and family), provided clinical interventions restricted to the microsystem, and did not conceptualize the community as the "patient" (White, 2003).

To find the conceptualization of wounded community and recovery community, one must go to those working within historically disempowered groups, particularly those working in Native American and African American communities (See Williams, 1992). One of the most riveting metaphors emerging from the Native American Wellbriety movement is that of the Healing Forest (Coyhis & White, 2003). In this metaphor, the clinical treatment of addiction is seen as analogous to digging up a sick and dying tree, transplanting it into an environment of rich soil, sunshine, water, and fertilizer only to return it to its original deprived location once its health has been restored. What is called for is treating the soil—creating a Healing Forest within which the health of the individual, family, neighborhood, community, and beyond are simultaneously elevated. The Healing Forest is a community in recovery.

Achieving this integrated vision of personal, family, and community recovery will require addiction treatment programs and recovery community service organizations to move beyond intrapersonal models of addiction recovery and conceptualize broader and more sustained interventions. More specifically, this will require strategies of outreach (extending the reach of treatment organizations into the community), inreach (involving indigenous community recovery support resources within the treatment environment), and community-based recovery resource development (facilitating broader processes of community healing) (White, 2009).

As behavioral health care systems shift from a focus on pathology to a focus on recovery and resilience, their vision and service technologies will inevitably be forced to see the individual nested within the ecology of family and community. As that happens, the interconnectedness of personal, family, and community health will become increasingly apparent, and talk of individual and family recovery will be extended to that of community recovery. In places like Alkali Lake, British Columbia, and Philadelphia, Pennsylvania, that process is well under way.

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Acknowledgement: Support for the development of this paper was provided by the Office of Addiction Services of the Philadelphia Department of Behavioral Health and Mental Retardation Services.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Davidson, L.; White, W.; Sells, D.; Schmutte, T.; O'Connell, M.; Bellamy, C.; & Rowe, M. (2010). Enabling or engaging? The role of recovery support services in addiction recovery. *Alcoholism Treatment Quarterly*, 28, 1–26. Posted at **www.williamwhitepapers.com**

Enabling or Engaging?
The Role of Recovery Support Services in Addiction Recovery

Abstract

Recovery capital—the quantity and quality of internal and external resources to initiate and maintain recovery—is explored with suggestions for how recovery support services (RSS) (non-traditional, and often non-professional support) can be utilized within a context of comprehensive addiction services. This paper includes a brief history of RSS, conceptual and operational definitions of RSS, a framework for evaluating RSS, along with a review of recent empirical evidence which suggests that rather than enabling continued addiction, recovery supports are effective at engaging people into care, especially those who have little recovery capital, and/or who otherwise would likely have little to no "access to recovery."



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2010). ONDCP guest blog: A new focus on recovery. Posted at http://www.ondcp.gov/ May 27, 2010. Posted at **www.williamwhitepapers.com**

ONDCP Quest Blog: A New Focus on Recovery

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Something quite historic is afoot at the Office of National Drug Control Policy (ONDCP). For the first time, recovery will be embraced as a pivotal organizing concept through the activities of ONDCP. During a recent visit with ONDCP staff, we discussed ways this new focus on recovery could help:

- celebrate the growth and diversification of American communities of recovery;
- reduce policy barriers to long-term addiction recovery;
- create platforms through which the voices of individuals and families in long-term recovery can be heard on key policy issues;
- develop and disseminate treatment models that incorporate prolonged recovery support and assertive linkages between professional and peer-based recovery support resources;
- formulate an addiction recovery research agenda; and
- facilitate international information exchange on creative and effective approaches to long-term addiction recovery support for affected individuals, families, neighborhoods, and communities.

The vision that emerged from our discussion was of a nation reaching and engaging individuals and families at earlier stages of problem development; providing accessible, affordable, and effective resources to achieve acute stabilization; guiding the transition from recovery initiation to long-term recovery maintenance; providing resources to enhance quality of personal and family life in long-term recovery; and breaking intergenerational cycles of addiction-related problems. The vision was of communities across the United States creating the physical, psychological, and cultural space where recovery and resilience can flourish and calling upon people who were once part of the problem to become part of the solution.

Recovery can be contagious. It can be spread interpersonally by recovery carriers—people whose character and quality of life exert a magnetic attraction to those still suffering. ONDCP has an opportunity to spread recovery by defining it, celebrating it, and mobilizing recovery carriers within communities across the country. Recovering people and their families are ready for such a call to service.



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Citation: White, W. & Kelly, J. (2010). Alcohol/drug/substance "abuse": The history and (hopeful) demise of a pernicious label. *Alcoholism Treatment Quarterly*, 29(3), 317-321 (2011). Posted at **www.williamwhitepapers.com**

COMMENTARY
(February, 2010)

Alcohol/Drug/Substance "Abuse": The History and (Hopeful) Demise of a Pernicious Label

William L. White, M.A. and John F. Kelly, Ph.D.

Words are important. If you want to care for something, you call it a "flower"; if you want to kill something, you call it a "weed."

--Don Coyhis

The language used to label alcohol and other drug (AOD) problems exerts a significant influence on people experiencing such problems and on how professional helpers, policy makers, and the public view such people. Whether AOD-related problems are viewed primarily in terms of medicine (illnesses), psychology (habits), sociology (norms), morality (vices), religion (sins), or law (crimes) rests on a choice of concepts and words. America's enduring and ambivalent relationship with psychoactive drugs is replete with cycles of stigmatization/de-stigmatization/re-stigmatization, criminalization/decriminalization/recriminalization, and medicalization/de-medicalization/re-medicalization. Put simply, we can't seem to make up our collective minds about these substances and the people who use them to excess. As a result, we have not achieved any enduring consensus on the language that best depicts AOD-related problems (White, 2004).

This brief commentary is about two such word choices—*abuse/abuser*—whose origins and shortcomings we will explore. We join a growing list of addiction professionals who have advocated the immediate and permanent removal of *abuse/abuser* from the lexicon of the addictions field and discouragement of their use in broader cultural discussions of AOD problems. Five arguments support this recommendation.

1. *The term <u>abuse</u> applied to substance use disorders is technically inaccurate.* Common definitions of the term *abuse* focus on acts of willful mistreatment, verbal intimidation/insult/humiliation, physical injury or deception (Abuse, 2010). To suggest that people with serious alcohol and other drug problems disregard, mistreat,

or defile the psychoactive substances they consume is a ridiculous notion. They do not *abuse* alcohol or drugs; they treat these substances with the greatest devotion and respect at the expense of themselves and everyone and everything else of value in their lives. The following anecdote illustrates the ridiculousness of this notion. When asked many years ago what he thought would constitute the *abuse* of alcohol, Alex B., a person in long-term alcoholism recovery, cryptically responded to the author (W.W.), "mixing Jack Daniels Tennessee Whiskey with Hawaiian Punch: anyone who would commit such an abhorrent act deserves serious punishment."

2. *The terms alcohol/drug/substance abuse/abuser reflect the misapplication of a morality-based language to depict a medical condition.* The historical roots of the application of the term *abuse* to severe and sustained alcohol and other drug problems are found not in medicine but in religion. References to alcohol/drug/substance *abuse* are rooted in centuries of religious and moral censure (Benezet, 1774). In 1673, Increase Mather in his sermon, "Woe to Drunkards" proclaimed that alcohol was the "good creature of God" but that the "abuse of drink" was "from Satan" (Lender, 1973, p. 353. The *abuse/abuser* vocabulary has long implied the willful commission of abhorrent (wrong and sinful) acts involving forbidden pleasure, e.g., the historical condemnation of masturbation as *self-abuse* (Renaud, 1989). The terms have also come to characterize those of violent and contemptible character—those who abuse their partners, their children, or animals.

The weight of this history led the National Commission on Marihuana and Drug Abuse (1973) to conclude that "continued use of this term [*abuse*] with its emotional overtones, will serve only to perpetuate confused public attitudes about drug using behavior." It also led noted alcoholism scholar Mark Keller (1982) to castigate the term *alcohol abuse* as "opprobrious, vindictive, pejorative," and an "inherently nasty" phrase. There is no medical diagnosis other than *alcohol/substance abuse* to which the term *abuse* is applied as a diagnostic term.

3. *The terms abuse/abuser contribute to the social and professional stigma attached to substance use disorders and may inhibit help-seeking.* To refer to addicted individuals as alcohol, drug, or substance *abusers* misstates the nature of their condition and may contribute to their social rejection, sequestration, and punishment (Kelly, 2004). Allegation of this effect has been made for quite some time, but recent scientific studies confirm that the words we use to depict individuals with AOD problems do make a very real difference in how people perceive and respond to these problems. In one recent randomized study, health care workers attending two addiction/mental health conferences (*N* = 728) were asked to complete a survey, which included a short paragraph describing an individual as either a "substance abuser" or as "having a substance use disorder." The vignette described "Mr. Williams," who was having difficulty complying with a court-ordered substance-related treatment protocol. Half the study participants received the paragraph describing him as a "substance abuser," the other half received the paragraph describing him as having a "substance use disorder," with the rest of the wording identical. Participants were asked to read the paragraph and then answer a number of questions that assessed whether he ought to receive more punitive or therapeutic measures, whether he was a social threat, and whether he was more to blame for his failure to comply. Those receiving the "abuser" paragraph were significantly more likely to agree that Mr. Williams should be punished and was more to blame for his condition and failure to comply with the treatment protocol (Kelly & Dow, 2009; Kelly & Westerhoff, 2009). Thus, even among highly trained mental health clinicians, exposure to the *abuser* label produced a reliably different and more punitive and blaming attitude toward the same individual.

4. *The terms abuse/abuser inaccurately portray the role of personal volition in substance use disorders.* These

terms define AOD problems exclusively in terms of personal values, character, and personal decision-making. By implying that AOD problems are a function of bad choices and that people should be accountable for such choices, the terms provide a rationale for policies of forced sequestration and mass incarceration of people with severe AOD problems. Use of these terms ignores how volitional control over AOD-related decision-making can be compromised by personal vulnerabilities and drug-induced neurological changes in the brain. The terms, by focusing on the individual casualties of AOD consumption, also deny the culpability of corporations whose financial interests are served by promoting high frequency, high quantity AOD consumption.

5. *The use of the abuse diagnosis by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) perpetuates and legitimizes the continued stigmatization of people with AOD problems.* This, in addition to growing concerns about the scientific validity of *alcohol/substance abuse* as a diagnostic classification (Harrison, Fulkerson, & Beebe, 1998; Hasin et al., 2003; Hasin, Hatzenbueler, Keyes, & Ogburn, 2006) and the widespread social convention of describing all adolescent substance use as *abuse* (Harrison et al., 1998), should be grounds for considering abandonment of the *abuse* language with the diagnostic nomenclature of psychiatry.

The terms *abuse* and *abuser* should be now and forever abandoned in reference to alcohol and other drug-related problems and those experiencing such problems. Such an action would include dropping *abuse* from the field's diagnostic language and changing the names of the field's major research and policy organizations: The National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment (White, 2006). If we truly believe that substance use disorders constitute serious health problems, legitimate medical disorders, and at their core, brain diseases, then why do we continue to have departments and centers of substance *abuse*? It is time—no, past time—that the terms *abuse/abuser* were dropped from the lexicon of addiction professionals and recovery advocates.

Acknowledgement: This commentary is dedicated to Mark Keller, James Royce, Mel Schulstad, Neil Scott, and other addiction professionals and recovery advocates who for years have been calling for the field to abandon the *abuse* language.

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Citation: White, W., Taylor, P. & McDaid, C. (2010). Recovery and citizenship. Posted at **www.williamwhitepapers.com** and **www.facesandvoicesofrecovery.com**.

Recovery and Citizenship
William L. White, Pat Taylor, and Carol McDaid

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The organizing constructs (or "governing images"; Room, 1978) for the resolution of alcohol and other drug problems have evolved through three overlapping stages:

1) A pathology paradigm, where knowledge is drawn primarily from studying the problem
2) An intervention paradigm, where knowledge is drawn primarily from studying prevention and treatment
3) A recently emerged resilience and recovery paradigm, where knowledge is drawn primarily from study of the lived solution (White, 2005, 2008).

The growing interest in recovery as an organizing concept has sparked multiple efforts to more precisely define *recovery*. Two of the more prominent of these efforts are illustrative.

The Betty Ford Institute hosted a field consensus conference that defined addiction recovery as a "voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (Betty Ford Institute Consensus Panel, 2007; also see McLellan, 2010). The United Kingdom Drug Policy Commission (2008) subsequently defined recovery as "voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society." Both recovery definitions posit a changed relationship to community as an essential ingredient of addiction recovery. The purpose of this essay is to discuss the role of citizenship in addiction recovery. More specifically, it explores three questions:

1) Why is *citizenship*—reconstruction of the person-community relationship—proposed as a criteria for addiction recovery when it is not a criteria for recovery from other medical disorders?
2) What does citizenship mean in the context of addiction recovery?
3) How can addiction treatment programs and recovery community organizations enhance core citizenship skills and activities of the individuals and families they serve?

Why Citizenship?

Recovery from any disorder is measured by changes in the precise areas affected by the disorder. The historical precedent in medicine is an inextricable link between each criteria or measure of recovery and the specific source and symptoms of the disorder. For example, recovery from a burn to one's hand is not measured by how well one can ambulate nor is recovery from cancer measured in terms of reduced criminality because there is no known connection between these dimensions. So why is citizenship one of the criteria for recovery from a substance use disorder? Would making citizenship one of the key recovery criteria reflect the moral overtones that have historically been attached to people with addiction? Would it constitute an inappropriate imposition of prejudice and moral values into the arena of medicine? It is our contention that citizenship should be considered a critical dimension of addiction recovery. Distortions in character and disruptions in social relationships are hallmarks of addiction (White, 1996).

Addiction inevitably involves a process of self-encapsulization, drawing into oneself, and reducing or withdrawing from intimacy with others. The addictive relationship with the drug drains and distorts the self, progressively displacing all other needs in importance and recasting others as objects to be used in service to the drug relationship. As the drug assumes the central value and ever-growing space in one's life, addiction becomes a disease of disconnection—from one's own aspirational self, from family and friends, and from identification with and relationship to community and culture. Addiction wears the mask of narcissism, but it produces a self-centeredness that is more aptly described as drug-centeredness. The self is actually lost in the process—a loss further magnified by family and community disconnection and social alienation. What remains at the end is either extreme isolation or migration towards a subterranean culture of addiction.

Recovery from addiction is thus rediscovery or development of an authentic self, a reconnection or reformulation of family, and a new social contract with one's community and culture. Citizenship is a component of recovery because addiction so often leads to the abandonment of one's connection and commitment to community. For some, this involves withdrawing their assets from the life of the community; for others, this involves threat to or inflicting harm on the community and its citizens. It is therefore not surprising that for nearly two centuries, addiction recovery frameworks have involved public confession, public commitment, socially supported recovery maintenance, and amends by the individual to the community via various forms of service work.

Citizenship and Recovery

The social contract of citizenry holds that each of us accrues certain rights and privileges if we accept the responsibility of contributing to the health and wellbeing of the whole society. Those rights and privileges require various tickets of access: an identity card, a driver's license, a voter registration card, an employee or student ID, proof of insurance, a professional license, a checkbook, a credit card, a library card—all evidence of connection to community. These symbols convey, in part, that we are productive members of society. It is not unusual for persons in later stages of addiction to have lost all of these symbols of community connection. Thus, over its long course, the recovery process for many must involve:

- a renewal or reformulation of self (visibly evident through the acts of story reconstruction and storytelling—the cleaving of one's life into categories of before and after to depict both addiction and recovery),
- a shift in social identity from outsider to insider—seeing oneself as a piece of the community whole,

- community connection via the expansion of non-drug social relationships, and
- community service—a shift from being a community burden to being a community asset.

The process of recovery involves reconstructing character (an alteration in beliefs, values, and behaviors) to redefine a person's relationship to community.

Community-Facilitating Recovery Values: To guide this new or renewed social contract, certain key values need to be cultivated or re-embraced. These recovery-grounded values include:

- primacy of recovery (maintaining recovery by any means necessary—under any circumstances),
- identification (empathizing; recognizing self in others),
- humility (accepting personal imperfection; when wrong, admitting it),
- respect (considering the needs of others),
- nonmaleficence (stopping injury to others),
- service (helping others),
- responsibility (doing our duty),
- restitution (making amends to those we've injured),
- forgiveness (letting go of past grievances),
- honesty (telling the truth),
- discretion (respecting confidences; avoiding gossip),
- loyalty and fidelity (keeping promises and commitments),
- justice (being fair),
- gratitude (passing on good fortune to others), and
- tolerance (respecting differences) (White, 2001).

These recovery-grounded values pervade religious, spiritual, and secular frameworks of recovery across time and cultures. Actualizing these values creates opportunities for people to reconnect with families and communities—a process central to addiction recovery. These values shift the focus from *recovering from* to *recovering to*—from what a person is removing from his or her life to what is being added.

Core Acts of Citizenship: Recovery-grounded values can inform daily activities in a range of areas including family, social, cultural, economic, and political participation, as well as shared life meaning and purpose. Here are examples of representative activities.

1. Family Participation (intimacy and legacy)
   - Accepting support from family members
   - Participating in family rituals and activities
   - Offering support to family members
   - Repairing intimate relationships
   - Accepting parenting responsibilities
   - Paying child support
   - Caretaking of elders
2. Social Participation
   - Sober socializing with friends
   - Social networking via the internet

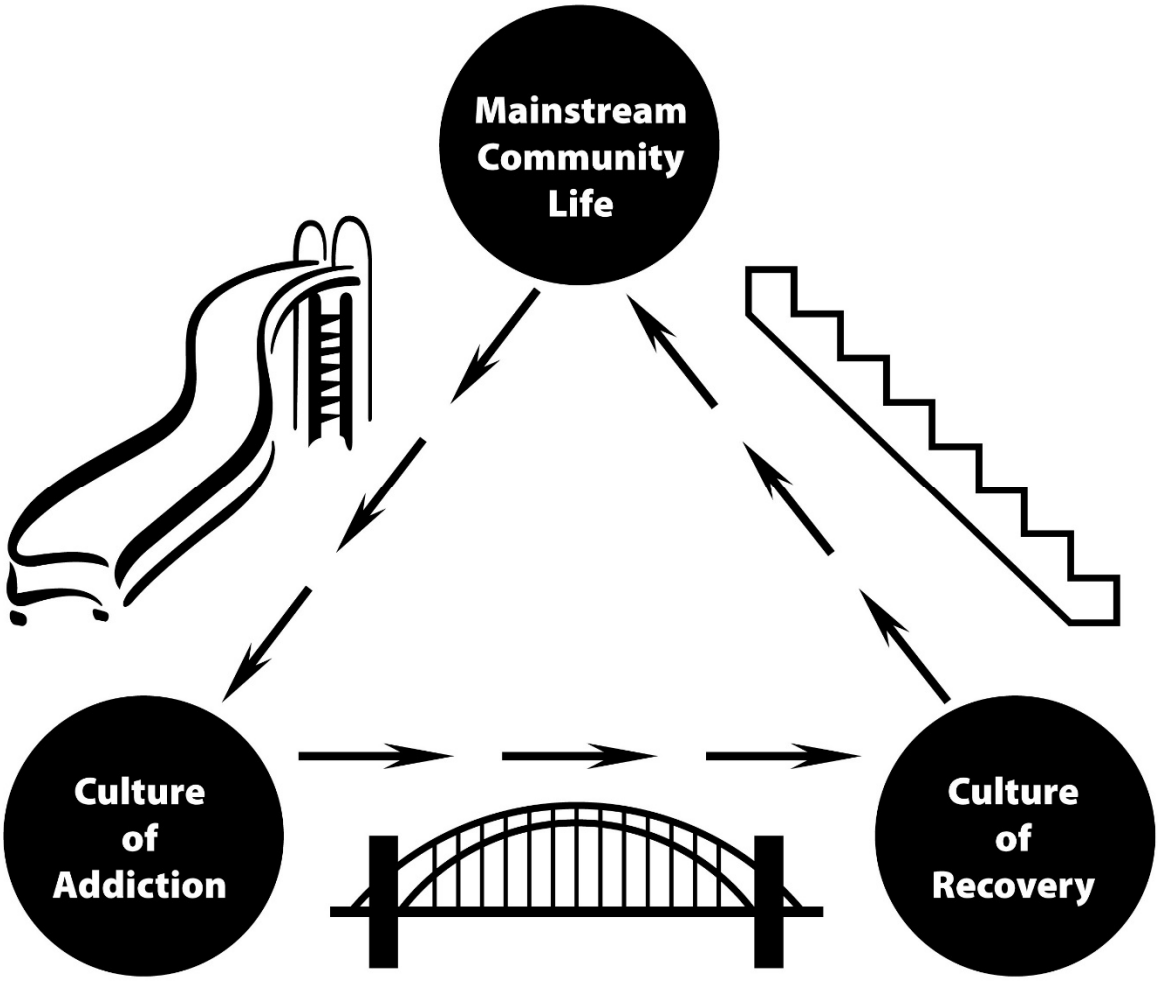
- Participating in a social support group
- Visiting with or helping a neighbor
- Participating in a professional association
- Participating in a health club or exercise class
- Participating in a PTA, club, or civic organization

3. Cultural Participation
   - Parks
   - Museums
   - Libraries
   - Theatre
   - Cinema
   - Concerts
   - Athletic Events
   - Keeping up on local, national, and international news
4. Economic Participation
   - Financial restitution
   - Employment or educational development
   - Debt Management
   - Bank account
   - Paying child support
   - Paying taxes
   - Home ownership
   - Business ownership
   - Making charitable contributions
5. Political Participation
   - Supporting a recovery advocacy organization
   - Participating in a recovery advocacy event
   - Speaking publicly about recovery
   - Attending a political event
   - Voting
   - Testifying before a legislative body
   - Attending community governance event, e.g., town council, tribal council
   - Making political contributions
   - Campaigning for a particular candidate or issue
   - Writing an issue-focused letter to the editor or blog
   - Participating in a political protest event
6. Shared Life Meaning and Purpose
   - Attending spiritual/religious services
   - Belonging to a spiritual/religious institution
   - Participating in religious or community service work

Recovery as a Cultural Journey

Many people with addiction become progressively isolated from mainstream community life and enmeshed in drug-focused subcultures. Their immersion in this lifestyle makes it very difficult to re-enter community life following recovery initiation. There are cultures of recovery that can act as sanctuaries and way stations to prepare and guide people back into mainstream community life. This process of withdrawal and re-engagement could be graphically depicted as the movement from mainstream community life into the culture of addiction, the journey from the

culture of addiction to the culture of recovery, and the subsequent re-entry into mainstream community life.



Addiction and recovery journeys are highly personal and variable. Some people with addiction continue their illness while maintaining an active life in the community; others have never been part of mainstream community life and may have even been born and raised within the culture of addiction. Some people in recovery remain cloistered within the culture of recovery while others participate in the recovery culture and become fully involved in the larger life of the community. Still others initiate and sustain recovery without connection to communities of recovery. These variations of addiction and recovery have been described as culturally enmeshed, bicultural, and acultural styles of recovery (White, 1996). For people with the most severe, complex, and chronic alcohol and other drug problems, extreme disconnection from mainstream community life is likely. These individuals may need guidance in reconnecting to community and assuming their citizenship rights and responsibilities.

Facilitating Citizenship in Recovery

Addiction treatment programs and recovery community organizations can play significant roles in enhancing citizenship skills and community integration of people in recovery by:

- assuring access to community participation by reducing social and professional stigma attached to addiction and recovery,
- evaluating degree of community disconnection and citizenship skills as part of the global assessment process,
- facilitating acquisition of citizenship "credentials" for persons seeking recovery,
- providing education and training to enhance citizenship skills,
- providing personal guides to facilitate community re-entry, and
- sponsoring or linking to opportunities for community participation and community service.

Addiction recovery is being increasingly defined in terms of three core elements: 1) sobriety (or diagnostic remission), 2) progress toward global health, and 3) citizenship. Frameworks of recovery (e.g., religious, spiritual, and secular recovery mutual aid societies) have long suggested activities that facilitate reconnection to community. We are just beginning to understand this third dimension, citizenship, and how it can best be enhanced and measured. This frontier is a worthy arena for research and service experimentation.

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RECOVERY TO PRACTICE
Resource Center for Mental Health Professionals

Weekly Highlight

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

August 13, 2010 Issue No. 14

Recovery in Mental Health and Addiction

Larry Davidson, Ph.D., and William L. White, M.A.

As noted in a previous Recovery to Practice Weekly Highlight, a number of common questions keep popping up related to recovery, the nature of recovery-oriented practices, and the ways they may differ from conventional mental health care. We are currently collecting these questions so they can be posted in the "Frequently Asked Questions" (FAQs) section of the RTP Website. We invite readers to suggest their own questions for this growing list.

This Weekly Highlight will be devoted to one of these emerging questions. Again, you, the reader, are invited to comment on and/or submit your own responses to the question raised. You can send your submissions to the Recovery to Practice Resource Center at RecoveryToPractice@dsgonline.com.

This week, we focus on FAQ #6.

Frequently Asked Question #6: ***"How does mental health recovery interface with the addiction recovery movement?"***

Our Response: In the United States, the mental health and addiction fields have different historical roots and traditions. These differences naturally led to there also being two distinct groups of practitioners who had little to do with the other specialty. If a person had both a mental illness and an addiction, it would have been difficult for him or her to receive optimal care. Either the mental health practitioner would not have been trained to identify the signs of substance misuse and/or the addiction practitioner would not have been trained to identify psychiatric symptoms. Even when a practitioner was able to identify both disorders, the best he or she could do was to refer the person for care for the "secondary" condition by a practitioner from the other camp.

Several important developments are changing this picture. First, both fields have come to recognize the high prevalence of what are now called "co-occurring disorders," meaning that many people with mental health conditions also have addictions, just as many people with addictions have mental health conditions. Research has consistently shown that for these individuals to receive effective care, mental health and addiction services must be integrated.

Integration has been difficult, however, for numerous political, fiscal, structural, and attitudinal influences that have been hard to overcome. Previous efforts at integration also have been difficult because they have focused primarily on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by each, failing to establish a common ground that would provide a foundation for integration. As long as the focus has been on the nature of the illness or on the treatments required, historical differences have outweighed commonalities, leaving the fields splintered.

Within the past decade, though, the emergence of a recovery movement in both the mental health and addiction fields has begun to offer a new organizing principle for bringing these two disparate worlds together. As integration has yet to be achieved from focusing on the nature of the disorders or the services required, perhaps concentrating on the processes of recovery, healing, and community inclusion will. As a core principle of both recovery movements suggest, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction have not been able to do. What results is recognition that, while mental illnesses and addictions might be different from each other in important ways—especially when viewed through the lens of a diagnostic manual—processes of recovery may nonetheless be very similar, and at times, even interwoven—especially when viewed from the perspective of the person in recovery. This Highlight will address both the differences and similarities, but will start with the similarities.

The components of an integrated recovery vision begin with the idea that, in both mental illness and addiction, recovery is a personal and individualized process of growth for which there are multiple pathways. People in recovery from either mental illness or addiction have described recovery as a transformational process (sudden, unplanned, permanent) and an incremental process (marked by multiple phases), and recovery narratives are often filled with elements of both types of change. Of central importance within these stories is the fact that within these stories, people in recovery are active agents of change in their own lives—not simply passive recipients of care. These stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and the discovery of previously hidden healing resources within and beyond the self. Recovery narratives often give prominence to the role of diverse religious, spiritual, and secular frameworks in recovery initiation and maintenance. People in recovery also note the role of family and peer support in making a difference in their recovery.

Whether they are living with a mental illness, an addiction, or both, people in recovery need to have hope. They also want to manage or eliminate their symptoms, increase their capacity to participate in valued social roles and relationships, embrace purpose and meaning in their lives, and make worthwhile contributions to their communities. With this shared vision in place, then, differences that have historically existed between the recovery visions of the mental health and addictions systems can now provide opportunities for synergistic growth in both.

In developing recovery-oriented practices and systems that are based on this integrated vision, several guiding principles exist. The first is that both mental illnesses and addictions span a

diversity of population and outcomes. Basically, recovery looks different for different people. Second is the need to adopt a long-term, longitudinal perspective and to use a developmental framework for matching the person's point in the recovery process to appropriate interventions. Also important is the impact of the environment—one must focus on person–environment fit and interactions. Third is the nonlinear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome. Finally, as previously noted, is the importance of family involvement, peer support, and spirituality in supporting the recovery process.

Recovery-oriented care is based on the recognition that each person must be either the agent of and/or the central participant in his or her own recovery journey. All services and supports, therefore, need to be organized to support the developmental stages of this recovery process. It follows from this core value that services also should instill hope; be person and family-centered; offer choice; elicit and honor each person's potential for growth; build on a person's/family's strengths and interests; and attend to the person's overall life, including health and wellness. These values can be the foundation for all services for people in recovery from mental illness and/or addiction, regardless of the service type (e.g., treatment, peer support, family education, etc.). There are many pathways to healing—both inside and outside of the formal health system—that people with mental illnesses and/or addictions can take in their recovery.

That said, what significant differences remain? Apart from the neurophysiology of these disorders, which remains to be determined, one important difference is in the role of behavior change. A useful model of behavioral change that has led to a popular approach to addiction treatment has been the Transtheoretical Model, proposed by DiClemente and Prochaska in 1985. This is the model at the heart of motivational interventions that attempt to facilitate a person's movement along the continuum from pre-contemplative and contemplative to preparation and then action (leading eventually to maintenance). While this model, tailored to the person's stage of change, has been effective in promoting recovery in addiction, its use in relation to mental illness is not as straightforward. This is because the Transtheoretical Model of Change is a model of behavioral change, and the role of behavioral change in mental health is somewhat different from that in addiction. That's because while you can choose not to drink alcohol or use an illicit substance, you cannot choose to stop experiencing the symptoms of a mental illness.

A person can, and does, make many choices when living with and recovering from a mental illness, of course, but these choices are different from the choice to use or not to use. For people in recovery from a mental illness, choices include what they do *in response to* experiencing symptoms (e.g., do what the voices command or try to ignore them); what they do *to prevent or minimize* symptoms (e.g., avoid stressful situations, take medication); and what they do *to manage or overcome* the disorder (e.g., learn self-care skills, reach out to others). But the primary role of behavioral change in addiction may need to be somewhat modulated by the variety of factors that also influence the onset and course of serious mental illnesses, factors that lie outside of the person's own sphere of influence. These include social

conditions, such as poverty, discrimination, and unemployment, as well as interpersonal and biological factors, such as the availability of social support and the responsiveness of symptoms to medications. As we learn more about the neurophysiology and social dimensions of addiction, we may eventually find that this is an area in which the addition field has much to learn from the mental health field. The increasingly important role of recovery support services in addiction care—services, such as case management, that in the past were sometimes viewed as "enabling"—certainly suggests that just such a change is already beginning to take place.

Upcoming SAMHSA Meeting: People in Recovery and Mental Health Consumers in Dialogue

On August 18–19, 2010, SAMHSA will convene a dialogue meeting of people in recovery from addictions and mental health consumers to examine the concept of recovery from an integrated, behavioral health perspective. All invited participants will represent the voices of recovery. The discussion will identify a common working definition for behavioral health recovery, unique factors for each field, and recommendations for ongoing efforts in support of behavioral health integration.

Drawing on the insights and experiences offered by dialogue meeting participants, SAMHSA will produce a report based on both the process and outcomes of the meeting. The report will include a working definition of behavioral health recovery, elements of a recovery-oriented system, and potential measures of recovery from an integrated behavioral health perspective. Unique and/or divergent issues will also be identified, along with implications for behavioral health services and systems. The report will also include specific suggestions and recommendations developed by meeting participants for SAMHSA and others in the field on what recovery means for behavioral health systems.

An announcement will be made via the RTP listserv when the report is completed and available for download and/or ordering from the SAMHSA Health Information Network (http://www.samhsa.gov/shin).

For Further Reading:

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Save the Date

The Recovery to Practice Resource Center is pleased to announce the second Webinar of its 2010 series,

"**What Recovery Means for Acute Care**."

It will take place September 16, 2010, from 3:00 p.m. to 4:30 p.m. EDT.

More information on how to register will be forthcoming!

We welcome your views, comments, suggestions and inquiries.

For more information on this topic or any other recovery topics, please contact the *Recovery to Practice* Resource Center at

1-877-584-8535 or email RecoveryToPractice@dsgonline.com

The views, opinions, and content of this Weekly Highlight are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Posted at **www.williamwhitepapers.com**

Recovery is Contagious

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Many of us in this room know that addiction is contagious. Addiction was not a purpose we set out to achieve. We grew up in a world that castigated people with drug problems as *dope fiends*, *crack heads*, *drunks*, *winos,* and worse. None of us wrote an essay in 5th grade saying we wanted to be an *addict* when we grew up. One day in our lives, we chose to pick up, but we didn't choose what followed. None of us wanted to so wound ourselves and those we love. We tried but could not prevent that harm from happening. Our addiction was not a choice; it was something we got caught up in and lost control over. Addiction is a disease of exposure—a collision between personal vulnerability and social opportunity. And that opportunity is often bred within psychological and social circumstances that made picking up again and again an attractive choice.

As a culture, we have recognized this process of social contagion. We have long referred to surges in alcohol and other drug problems as *epidemics*—a term most often applied to communicable diseases. But I am not here tonight to talk about disease. I am here to talk about recovery—something we rarely think of in terms of contagion. We usually think of recovery as something that arises from deep inside someone. We think of it as those rare transformative experiences like Bill Wilson experienced in a hospital room and Malcolm X experienced in a jail cell, or we think of it as a slow process of internal change—a process of spiritual awakening.

Folk wisdom says recovery comes only when we hit our own personal bottom. But recovery did not come to some of you in this room by hitting bottom. Some of you lived on the bottom, and recovery remained a stranger. Some of you were drowning in pain, had lost everything but your life to addiction—and recovery still did not come. When it finally arrived, it wasn't forced on you and you didn't initially choose it. You caught recovery in spite of yourself. And you caught it from other people in recovery—from people here at NET and from people in the recovery fellowships meeting every day throughout this city.

Let me be clear and brutally honest. Some of you did not come to NET seeking recovery. Many of you had never even seen long-term recovery in the flesh—had no idea what it even looked like. Many of you came to treatment not because of the monkey on your back, but the people on your butt. Some of you came looking not for recovery but respite—a break from the life, not an end to it. Some of you came to escape the threat of jail. Some of you came to keep or get back important people in your life. The reasons were many and may have changed every day, but recovery was not at the top of that list. And yet many of you have started what will be a lifelong recovery journey. So how did this miracle happen?

My message tonight is a simple one: Recovery is contagious. That message is the centerpiece of the recovery revolution sparked by the leadership Dr. Arthur Evans, Jr. brought to the City of Philadelphia more than five years ago. That message is what has made NET one of the leading treatment centers in the country. And there is no better example of this process than what is happening right here, right now. This night is a celebration of the contagiousness of recovery and the fulfilled promises recovery has brought into our lives. Some of you did not leave the streets to find recovery; recovery came to the streets and found you. And it did so through volunteers of the NET Consumer Council walking those streets. They put a face and voice on recovery. They told you that recovery was possible, and they offered their stories as living proof of that proposition. They told you they would walk the road to recovery with you. Some of you hit low points in the early days of that journey, and it was your brothers and sisters in this room that lifted you back up—who called when you missed group, who, in some cases, went and got you. Many of you were buried deep within a culture of addiction—a way of thinking, feeling, acting, and relating as powerful as the drugs you were taking. The NET community and the larger recovery community of Philadelphia helped you escape and welcomed you into membership in another world—a culture of recovery. And this moment we are sharing together tonight stands as witness to the vitality of that recovery culture.

Recovery is contagious only through interpersonal connection—only in the context of community. For those still in the life to find hope and recovery, they must take the unlikely risk of leaving their cocooned world or we must risk going to get them. The outreach work of the NET Consumer Council has a poignant message for this country's efforts to prevent and treat addiction. If we are really serious about addiction, then we should reach those who are at early stages of their addiction careers and not wait until decades of devastation finally bring them to the doors of a treatment center. We need to correct the community conditions in which addiction flourishes. We need to protect those most vulnerable to addiction. We need assertive intervention programs that shorten addiction careers and extend recovery careers. To achieve those goals, we must carry resilience and recovery into the very heart of local drug cultures. We must make the transformative potential of recovery visible to those who need it the most.

The contagion of addiction is transmitted through a process of infection—the movement of addiction disease from one vulnerable person to another. The contagion of recovery is spread quite differently—not

through infection, but affection.[1] Those who spread such affection are *recovery carriers*. Recovery carriers—because of the nature of their character and the quality of their lives—exert a magnetic attraction to those who are still suffering. Recovery carriers affirm that long-term recovery is possible and that the promises of recovery are far more than the removal of drugs from an otherwise unchanged life. They tell us that we have the potential to get well and to then get better than well. They challenge us to stop being everyone's problem and to become part of the solution. They relate to us from a position of profound empathy, emotional authenticity, respect and moral equality—lacking even a whisper of contempt. Most importantly, they offer us love. Yeah, some of us got loved into recovery, and I don't mean in the way some of you with smiles on your faces may be thinking. The affection at the heart of the recovery community you have created here at NET is being extended as a force for building resistance, resilience, and recovery within the larger Philadelphia community and beyond.

We all have the potential to be recovery carriers. Becoming a recovery carrier requires several things. It requires that we protect our recoveries at all cost—*Recovery by any means necessary under any circumstances*. It requires that we help our families recover. It requires the courage to reach out to those whose lives are being ravaged. It requires that we give back to NET and other organizations that helped us along the way. And it requires that in our new life, we try to heal the wounds we inflicted on our community in our past life.

Addiction is visible everywhere in this culture, but the transformative power of recovery is hidden behind closed doors. It is time we all became recovery carriers. It is time we helped our community, our nation, and our world recover. To achieve this, we must become recovery. We must be the face and voice of recovery. We must be the living future of recovery.

So to all who are here tonight—individuals and families in recovery and allies of recovery, I leave you with this message. **Recovery is contagious. Get close to it. Stay close to it. Catch it. Keep catching it. Pass it on.**

[1] I wish to acknowledge Kathy Griffin, who was present at the NET dinner and first brought this distinction to my attention.



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Relapse is NOT Part of Recovery: A Brief Commentary

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One does not have to travel far in the American alcohol and other drug problems arena to hear the phrase, "relapse is part of recovery." The history of the phrase is unclear, although it seems to be of relatively recent origin. The phrase was not present when I entered the worlds of addiction treatment and recovery in the late 1960s. It began appearing with some frequency in addiction treatment conferences and trade journals in the late 1970s and 1980s and inevitably seeped into the meeting rooms of various recovery fellowships. I suspect the early intent of this phrase was a benign one—offering solace and hope to individuals (and their families) being readmitted to addiction treatment or returning to a recovery mutual aid fellowship following additional "research." One can easily imagine how a counselor or sponsor would positively spin renewed recovery initiation efforts by pointing out important lessons that could possibly be extracted from the recent experience of resumed drug use. However, those good intentions obscure the harm that has come from this simple idea and phrase. It is time—no, past time—we as addiction professionals and recovery advocates abandoned the idea and the phrase. Here are six reasons why.

1. "Relapse is part of recovery" blurs the distinction between pathology and health. One does not hear people describing a reoccurrence of cancer, heart attack, or stroke as part of their recovery from these disorders. Marrying relapse and recovery attaches unwarranted value and nobility to the resumption of drug use and its inevitable consequences. Let's be very clear: the resumption of drug use by someone with a history of addiction is part of the addiction process—in fact, such persistent use is part of the defining criteria of addiction, not part of the process of getting well. Symptoms of illness and progress towards recovery co-exist for most disorders, particularly chronic disorders, but framing symptoms of illness within a recovery rubric destroys the very meaning of recovery. Casting relapse as a dimension of recovery is more than the medical equivalent of putting lipstick on a

pig; it injects pathology within the very concept of health and wellness. Illness and health by definition constitute different states. Mushy Ideas and language that blur this distinction undermine addiction recovery by failing to clearly delineate the condition one is seeking to escape from the state to which one is aspiring. "Relapse is part of recovery" has currency only when one has not yet fully experienced the latter.

2. "Relapse is part of recovery" fails to acknowledge the potential for permanent recovery with no continued episodes of drug use. As such, it sets the bar of recovery low, fueling pessimism and deflated expectations for people seeking recovery, their families, their employers, and others with significant influence in their lives. A significant percentage of people completing addiction treatment and/or joining an addiction recovery mutual aid society will never use alcohol or other drugs again in their lives. It is time we acknowledged and celebrated that achievement and that potential for others newly seeking recovery.

3. "Relapse is part of recovery" minimizes the pain and potential loss of life involved in the resumption of alcohol and other drug use. Imagine the loved ones of someone with a history of addiction who died in an episode of resumed alcohol or drug use. Or imagine the loved ones of a person disabled or killed in a crash resulting from an impaired driver with a history of failed attempts at recovery. What must these individuals think and feel when they hear the phrase "relapse is part of recovery"? Resumption of alcohol and drug use within a prolonged addiction career can bring devastating and potentially fatal consequences. Masking this harsh reality behind phrases that portray such use as a helpful learning experience offensive and a disservice to everyone.

4. "Relapse is part of recovery" offers the person seeking recovery an invitation and excuse for continued use. By normalizing episodes of continued drug use, the phrase may well create its own self-fulfilling prophecy. Early recovery from addiction is often characterized by extreme ambivalence about both continued drug use and cessation of drug use. In the face of such ambivalence, successful recovery involves creating as much distance as possible between oneself and the recently severed drug relationship. The phrase "relapse is part of recovery" shortens rather than lengthens that distance.

People often bring impaired and distorted thinking to the act of recovery initiation. What is needed in this state are clear language and ideas about what constitutes progress towards health or regression towards re-addiction. "Relapse is part of recovery" lacks this critically needed clarity.

5. "Relapse is part of recovery" is a thin line away from the "once an addict, always an addict" mantra that has fueled decades of addiction-related social stigma. Such language contributes to social stigma by obscuring the potential for and prevalence of full recovery. What does this phrase mean to the spouse or partner deciding whether to remain in a relationship with a person seeking recovery? To the potential employer? To the landlord deciding whether to rent an apartment? To the child welfare worker deciding whether to recommend reunification of a mother and her children? To members of academic admissions committees? To loan officers? To life and health insurance carriers?

6. "Relapse is part of recovery" provides addiction treatment programs an escape from accountability for post-treatment recovery outcomes. It constitutes a request by treatment organizations for a blank check to continually readmit patients who have failed to achieve stable recovery and the right to place responsibility for continued drug use on the nature of addiction recovery and not the inadequate quality treatment methods. The phrase "relapse is part of recovery" has reaped significant financial rewards for the addiction treatment industry, but it has also contributed to public pessimism about addiction treatment. The addiction treatment industry should not be allowed to escape accountability for

recovery outcomes nor financially exploit its patients within the shroud of such euphemisms.

Addiction and recovery processes are far too complex to easily capture in simplistic slogans. It is my suggestion that the phrase "relapse is part of recovery" be immediately replaced with statements that are more morally neutral (See White & Ali, 2010), behaviorally precise, scientifically defensible, and therapeutically beneficial. In summary, such statements could include the following:

- Episodes of continued alcohol or drug use by people addicted to such substances are not an inevitable dimension of long-term addiction recovery.
- Many people who commit themselves to an addiction recovery process will never resume alcohol or other drug use in their lives following this commitment to self and others.
- More than half of all people who seek abstinence as a solution to alcohol and other drug problems via their admission to addiction treatment will use alcohol or other drugs at least once following their initial resolution to stop use and before they achieve stable (permanently sustainable) recovery.
- An episode of drug use following recovery initiation does not mean that permanent recovery in the future is not possible, but such episodes constitute part of the residual addiction process, not part of the recovery process.
- Episodes of resumed drug use are not part of long-term recovery, but the self-evaluation and recommitment following such episodes may for some individuals serve to bolster future recovery stability.
- There are sources of heightened recovery commitment (other than renewed episodes of drug use) that do not involve such risks of harm to self and others (e.g., prolonged addiction, disability, and death).
- Not everyone who achieves a period of prolonged recovery who then resumes drug use is able to re-initiate recovery. The adage that people may have another binge in them but possibly not another recovery is confirmed anew every day. Any potential lesson gained from renewed drug use is more than neutralized by threats such use poses to others and to oneself. Continued episodes of drug use fuels guilt and shame, exhausts relational recovery capital, and reduces the prognosis for long-term recovery and quality of life in recovery.
- Quality of addiction treatment is best measured via long-term addiction recovery—recoveries within which episodes of posttreatment AOD use are eliminated or reduced in number, duration, intensity, and consequences.
- Rates of post-treatment recovery and post-treatment AOD use vary considerably across treatment programs and across addiction counselors. Programs and individual counselors should be held accountable for such outcomes.

Recovery is emerging as an organizing construct for addiction treatment and the larger cultural resolution of alcohol and other drug problems. Injecting relapse into the concept of recovery is a step backward for affected individuals and families, for the addiction treatment industry, and for society as a whole. Relapse is NOT part of addiction recovery.

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social research

Research Findings
No.23/2010

Crime and Justice

Research for Recovery: A Review of the Drugs Evidence Base

David Best, Andrew Rome, Kirstie A. Hanning, William White, Michael Gossop, Avril Taylor and Andy Perkins

This review of the drugs evidence base was commissioned by the Scottish Government on behalf of the National Drugs Evidence Group. The main aim of the review was to show where the evidence base is already strong, what the evidence tells us and what we still need to know to support Scotland's National Drugs Strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*. It examines both the published evidence base and the policy context in which the strategy sits and this provides the link between the evidence base for addictions and the wider social, health and economic context in which recovery occurs. The review set out to assess what we know about 'what works' in drugs recovery and identify the core questions that need to be answered when assessing the effectiveness and impact of *The Road to Recovery*.

Main Findings

- The evidence base on recovery is growing, demonstrating that recovery-focused approaches can augment and enhance treatment interventions, and maximise wider benefits to families and communities.
- There is little UK-based research on recovery and the international evidence base is limited by three factors – much of it is quite dated, much of it is based on alcohol or mental health rather than illicit drugs, and almost all of the evidence originates from the United States.
- In the drugs research field, there is a considerable history of treatment effectiveness cohort studies and these consistently show significant improvements for clients in treatment services across a range of indicators including health, offending, risk-taking and substance use.
- Differences in the effectiveness of different forms of abstinence-oriented treatment (such as community detoxification and residential rehabilitation) have been less consistently researched and reported.
- With the exception of one medium-term (33 month) outcome study (Drug Outcome Research In Scotland - DORIS), there is little longitudinal treatment research in Scotland and very little clinical research activity. Thus, the evidence base is largely derived from English and international findings and from 'expert' reviews and policy guidance.
- However, there is a clear need for 'technology transfer' research to determine what can be learned from other settings, particularly mental health recovery and the substance misuse recovery experience in the United States, and to test its applicability to the drugs field in Scotland.
- Findings from this review emphasise: 1) the importance of providing ongoing support to individuals following structured treatment; 2) the positive outcomes associated with mutual aid and peer support in the community; and 3) the importance of assertive follow-up support as aftercare.
- The review highlighted an evidence gap on the impact of drug treatment aftercare in Scotland and there is a need for research and evaluation on this in the future.
- The overall consensus of key experts working in the drugs field, who were consulted as part of the review, was that a clear strategy is needed for developing a Scottish evidence base that will both inform the delivery of *The Road to Recovery* and assess its impact.
- The findings from this research could help to inform the commissioning and delivery of services in Scotland, the establishment of recovery-focused outcomes and indicators, and the involvement of service users and communities in developing knowledge about recovery and service provision.

The Scottish Government

Research Method

The main aim of this review was to show where the evidence base is already strong, what the evidence tells us and what we still need to know to support the drugs strategy. In doing so, the research mapped the evidence requirements of the Road to Recovery, reviewed the findings of existing evidence around recovery, assessed the quality of the available evidence base and identified key evidence gaps.

The research process involved two distinct phases:

1. A review of the available literature on recovery, what works in drug treatment, and the lessons that can be learned from related fields, particularly the mental health recovery movement, with a view to understanding how this evidence could inform policy making in Scotland.

2. A 'consultation' phase, in which key experts in the drugs field were interviewed about the findings of the literature review, the drugs evidence base in Scotland and internationally and the key gaps in current knowledge.

What do we know about recovery?

Although there is a limited UK recovery research base, some key conclusions can still be drawn:

- Sustained recovery is the norm, although the time to recover and the pathways involved are unique to the individual. For this reason, the evidence suggests that a narrow, 'diagnostic' definition of recovery is not advisable.
- The best predictor of the likelihood of sustained recovery is the extent of 'recovery capital'. This includes the personal and psychological resources a person has, the social supports that are available to them and the basic foundations of quality of life (i.e. a safe place to live, meaningful activities and a role in their community, however they define this).
- Barriers to recovery include psychological problems (mental illnesses and the absence of strengths, such as self-esteem), significant physical morbidities (including blood borne viruses), social isolation and ongoing chaotic substance use.
- Strengths (i.e. recovery capital) are a better predictor of long-term recovery than the symptoms of substance misuse.
- While structured treatment has a key role to play in an individual's recovery, it is only part of the support that most people will need to recover from their drug use. Ongoing support in the community is essential for maintaining and continuing the recovery journey.
- The individual is the central actor in the recovery journey and their empowerment, hope and strength are key predictors of their sustained recovery.
- Recovery is not just about the individual, but significantly it also involves – and impacts upon – families and communities.
- Switching to a recovery model is likely to require a fundamental change in culture and attitudes by many professionals and by communities.

What is the evidence for treatment outcomes?

There is a considerable history of cohort studies assessing short-, medium- and long-term outcomes for clients accessing different types of drug treatment. Findings from these studies consistently show significant improvements for clients across a range of indicators, including health, offending, risk-taking, substance use and social functioning.

Differences in effectiveness between different modalities of treatment have been less consistently reported. More recent outcome studies in the United States have switched focus from overall effects to the mechanisms of change, including service functioning and delivery, the client/worker alliance and client engagement and participation in the treatment process. This is based on findings that therapeutic relationships and overall service quality are important predictors of treatment engagement and outcomes for clients.

Other key findings have been that:

- There is a strong evidence base supporting methadone substitution treatment in maintenance settings, but this requires adequate psychosocial support and links to 'wraparound' care in addition to prescribing.
- Scottish outcome research (DORIS) has shown that while methadone maintenance leads to improved outcomes in a range of domains, it is associated with low rates of sustained abstinence.
- Continuity of care is a critical component of effective treatment systems, and there is a strong supportive evidence base around linkage to 12-step and other community 'aftercare' supports. However, the quality of current research evidence on aftercare packages is particularly poor.
- The evidence suggests that there is a problem with psychosocial interventions and that this is related to the structure of service delivery. While there is a strong evidence base available from clinical trials, there is little evidence that structured psychosocial interventions are routinely translated into everyday clinical practice.
- The issue of 'technology transfer' is part of a recent transition to assessing what allows the evidence base to be applied in real clinical settings with increased focus on the structure of services and their organisational functioning.

What can we learn from parallel fields?

Scotland has been at the forefront of the mental health recovery movement. The key underlying principles of recovery in mental health can be summarised as: the empowerment of the person in recovery; building their aspirations and expectations of recovery; focusing on the enabling role of the professional; and a much greater role for family and community engagement in recovery. This approach has changed the way that professionals engage with their clients and has required major shifts in professional cultures and workforce development. That said, much of the evidence to date in this field has been drawn from personal experiences, and systematic analysis has been more limited.

Equally important as the changing role of professionals and the empowerment of the person in recovery, is the increased role of communities. These provide the setting for recovery to occur, a foundation for supportive relationships and opportunities for vocational and personal growth, as well as a developmental platform for recovery.

Finally, there are lessons to be learned from criminal justice research, where the assumption is that desistance (or recovery) is the norm and that it is life transitions, rather than interventions, which are a key part of sustaining an individual's recovery journey.

While we should be cautious in translating lessons learned from recovery in other fields to drugs recovery, these approaches do promote some common themes:

- the central role of self-empowerment;
- the importance of the growth of self-esteem and self-efficacy and the importance of changed self-perception;
- the central role of the community and peer learning, rather than the clinic, and the benefits around communities of recovery;
- the recognition that recovery is both an ongoing and dynamic process of change.

What do we know in key areas?

Criminal Justice and Prisons

- Therapeutic Communities (TC) in a prison context are effective in reducing drug use and criminality, with outcomes further improved with follow-up aftercare. TC may be less successful among women and those with a dual diagnosis of mental health and substance use issues.
- Interventions for prisoners with a dual diagnosis of mental ill-health and substance use have shown limited effectiveness, although those receiving dual treatment are more likely to maintain contact with services. However, more research is required.
- US research suggests that interventions which take account of the multiple and complex needs of female offenders, such as post-traumatic stress disorder, can improve effectiveness and recovery, particularly where there is follow-up after release from prison.
- The evidence around the success of coerced treatment is mixed. Research from North America suggests coercion improves retention in treatment but not necessarily abstinence. Further research is required on the effectiveness of coerced treatment, especially in a Scottish context.
- Encouraging social skills, improving self-esteem and channelling substance misusing former offenders towards networks of social support have been found to help reduce reoffending.

Families

- US research suggests that family involvement in treatment programmes may improve outcomes.
- Teaching parenting skills as part of treatment programmes can improve retention in treatment and may reduce childcare associated stresses that can trigger relapse.
- Californian research suggests that mothers are more likely to have children returned to them from care where mothers remain in treatment for 90 days or more.
- Pregnant women tend to use treatment services more and undertake more intensive treatments, suggesting that pregnancy can be a turning point in drug misuse. Abstinence outcomes tend to be improved as a result, particularly where residential programmes are used.
- Supportive parents are key to adolescents becoming abstinent. Therapeutic communities and 12-step participation have also been shown to be effective with adolescents, but it may be necessary to frame the assisted recovery process as a part of the individualisation process associated with becoming an adult.

Prevention and Education

- There is a strong link between problem drug use and deprivation, suggesting tackling poor housing and employment could have a positive impact on recovery from drugs in Scotland, although it is also important to review other factors such as mental health, recreational use and peer networks. Research evidence on the efficacy of drug prevention initiatives is lacking.
- More risk factors and the absence of protective factors increase the likelihood of a young person developing a drug problem. However, there is a research gap around whether identifying and targeting vulnerable young people is an effective method of reducing substance misuse.

- Certain drug education models can deliver modest reductions in cannabis, alcohol and tobacco consumption in the short-term. However, there is generally a lack of robust evidence on effective drug education strategies, both within educational institutions and in the community.

Treatment and Intervention

- Treatment is generally effective although the structure and context is increasingly recognised as being important. US evidence suggests that a staged approach to recovery is effective. Long-term recovery is likely to be linked to social networks and the development of recovery capital.
- The evidence around the success of treatment for those with dual diagnosis of substance misuse and poor mental health is limited. Some treatment, mutual aid and integrated care approaches show promise but more rigorous trials are required.
- Women are less likely to access drug treatment than men, but once in treatment retention and outcomes are similar. There is a need to evaluate interventions for older women and women with dual diagnosis, as well as the benefits of mixed versus single-gender treatments.
- The therapeutic alliance and level of client engagement is an important predictor of treatment outcomes, with worker motivation and efficacy central. Professional staff from similar cultural backgrounds to clients can improve treatment engagement.
- In Scotland, people from black and minority ethnic groups are less likely to access drugs treatment than the population as a whole. Further research is needed to find out whether this reflects lower prevalence of drug use, poor reporting or barriers to services. Such barriers may reflect inadequate diversity training, lack of cultural understanding, language barriers and a lack of welcoming 'symbols of accessibility'.
- Using aftercare interventions, such as relapse prevention and 12-step which aim to build self-efficacy and confidence in clients, is likely to be an important step towards recovery. While there is strong evidence of the added value of engagement in mutual aid after formal treatment, there remain barriers for both clients and professionals.
- There is clear support for effective engagement in recovery housing and training and vocational support as parts of a recovery package of care, provided that work-related pressures do not compromise recovery needs.
- Effective continuity of care is essential with an increasing international evidence base around the benefits of assertive linkage to aftercare and community support. Quarterly post-treatment recovery check-ups have been shown to be effective in reducing relapse and in returning clients to treatment more quickly where relapse does occur.

Filling the gaps in evidence

The review confirms the need for a more strategic, programmatic approach to developing the drugs recovery evidence base in Scotland.

Building on this review, the Scottish Government and National Drugs Evidence Group will work towards agreeing a Drugs Evidence Framework, setting out the key priorities for new evidence that will help inform effective recovery in Scotland.

In addition, the authors of the review also recommend new structures – perhaps in the form of a Scottish Drugs Research Forum – to lead on research prioritisation and negotiation with key bodies around sustainable funding support for research and broader evaluation and audit work within Scotland.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: http://www.scotland.gov.uk/socialresearch. If you have any further queries about social research, or would like further copies of this research findings summary document, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 7560.

GOVERNMENT SOCIAL RESEARCH

Social Science in Government

ISBN: 978-0-7559-9504-2

9 780755 995042

APS Group Scotland
DPPAS10404 144632 (07/2010)

The Scottish Government

Research For Recovery: A Review of the Drugs Evidence Base

Crime and Justice

social research

RESEARCH FOR RECOVERY:
A REVIEW OF THE DRUGS EVIDENCE BASE

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Scottish Government Social Research
2010

This report is available on the Scottish Government Social Research website only www.scotland.gov.uk/socialresearch.

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Acknowledgements

The authors would like to thank all of the key informants who very kindly gave their time and thoughts to the team. We have been delighted by how helpful and insightful their contributions were and many of the conclusions and recommendations laid out in the final chapter are derived from their contributions.

We would also like to thank the officials from the Scottish Government, particularly Paul Bennett and Roisin Ash, who have provided us with excellent support throughout the course of the project. Finally, we would also like to thank the Research Team at Figure 8 and University of the West of Scotland who have not been credited with an authorship, but whose input has been essential in the project. Special thanks to Myshi Mackenzie and Kirsty Elliot at Figure 8.

LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
ABCD	Asset-Based Community Development model
AC	Acute Care
ACC	Assertive Continuing Care
ACMD	Advisory Council on the Misuse of Drugs
ACPOS	Association of Chief Police Officers in Scotland
ACT	Assertive Community Team
ADAT	Alcohol and Drug Action Team
ADP	Alcohol and Drug Partnership
AOD	Alcohol and Other Drug
ATOS	Australian Treatment Outcome Study
BBV	Blood-Borne Viruses
BME	Black and Minority Ethnic Groups
CA	Cocaine Anonymous
CAPSM	Children Affected by Parental Substance Misuse
CBT	Cognitive Behavioural Therapy
CCAP	California Civil Addict Programme
CCISC	Comprehensive Continuous Integrated System of Care
CoSLA	Convention of Scottish Local Authorities
CRGPD	Cross-Governmental Research Programme on Drugs
CSIP	Care Services Improvement Partnership
CSO	Community Service Order
DARP	Drug Abuse Reporting Programme
DAT	Drug Action Team
DATOS	Drug Abuse Treatment Outcome Study
DfES	Department for Education and Skills
DoH	Department of Health
DHC	Dihydrocodeine
DIP	Drug Interventions Programme
DORIS	Drug Outcome Research in Scotland Study
DRD	Drug Related Deaths
DTORS	Drug Treatment Outcome Research Study
DTTO	Drug Treatment and Testing Orders
DTX	Detoxification
ECA	Epidemiologic Catchment Area
EIU	Effective Interventions Unit, Scottish Executive
EST	Empirically Supported Therapies
EU	European Union
GROS	General Register Office for Scotland
GIRFEC	Getting It Right For Every Child
HEAT	Health, Efficiency, Access and Treatment (targets)
ISD	Information Services Division Scotland
LEA	Local Education Authority
LEAP	Lothians and Edinburgh Abstinence Programme
LGBT	Lesbian, Gay, Bisexual and Transgender
MI	Motivational Interviewing
MMT	Methadone Maintenance Treatment

MRC	Medical Research Council
NA	Narcotics Anonymous
NACD	National Advisory Committee on Drugs
NDEG	National Drugs Evidence Group, Scotland
NDTMS	National Drug Treatment Monitoring System
NIAAA	National Institute of Alcohol Abuse and Alcoholism
NICE	National Institute for Clinical Excellence
NIDA	National Institute on Drug Abuse
NIHCE	National Institute of Health and Clinical Excellence
NIHR	National Institute of Health Research
NSS	National Services Scotland (part of NHS Scotland)
NT	Not currently in Treatment
NTA	National Treatment Agency
NTORS	National Treatment Outcome Research Study
PDU	Problem Drug User
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Controlled Trial
RIOTT	Randomised Injectable Opioid Treatment Trial
RM	Recovery Management
RMC	Recovery Management Check-ups
ROIS	Recovery Oriented Integrated System
ROSC	Recovery-Oriented Systems of Care
ROSIE	Research Outcome Study in Ireland
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SAMHSA	Substance Abuse & Mental Health Services Administration
SAO	Supervised Attendance Order
SCIE	Social Care Institute for Excellence
SDF	Scottish Drugs Forum
SDMD	Scottish Drug Misuse Database
SIGN	Scottish Intercollegiate Guidelines Network
SIHVSC	Scottish Parliament Social Inclusion, Housing and Voluntary Sector Committee
SMART	Self Management And Recovery Training
SMR (25)	Scottish Morbidity Record (25)
SPS	Scottish Prison Service
SRN	Scottish Recovery Network
TC	Therapeutic Community
TOPS	Treatment Outcome Prospective Study
UKDPC	UK Drug Policy Commission

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EXECUTIVE SUMMARY

Background: The publication of *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* by the Scottish Government in 2008 signalled a fundamental shift in the way we think of problem drug use and in the approach to the types of interventions that are appropriate to address it. In particular, the switch to a recovery model represented the recognition that the resolution of addiction problems involves not only the drug user, but also their families and communities. It also recognises that recovery is a complex process likely to endure over a number of years after the point of stabilisation or abstinence, and that it is likely to involve fundamental changes in an individual's social functioning and personal wellbeing, as well as in their place in their community and wider society.

The aim of this review was to assess the current state of the evidence base that will help underpin the delivery of the Scottish Government's drugs strategy – *The Road to Recovery*. The review examined both the published research base and also the policy context in which the strategy sits, – this provides the link between the evidence base on addictions and the wider context of social inclusion, public health and economic development.

Rationale and methods: The project team divided the review into two phases – an initial 'documentary' phase and a subsequent 'testing' phase.

The documentary phase of the project involved the following components:

1. A review of the international literature in relation to what we know about 'recovery' in the addictions field and an evidence-based appraisal of 'what works' in this area.
2. An overview of the international literature on drug treatment effectiveness and of international, UK and Scottish studies that have assessed treatment outcomes.
3. A review of what lessons can be learned from other academic and applied areas – particularly the evidence around the mental health recovery movement, given the prominence this has achieved through the work of the Scottish Recovery Network. Other domains assessed in this area included community development, positive psychology, alcohol outcomes and developmental approaches to crime careers.
4. A review of the recently published literature examining three questions: recovery-focused research; treatment effectiveness; and treatment outcomes.

The synthesis of these four strands of work led to the production of an initial report that was shared with the research advisory group and the National Drugs Evidence Group in Scotland. Initial feedback was collated prior to the 'testing' phase of the review, in which key experts were identified and interviewed, (where possible), about:

- The quality of the evidence base for recovery in Scotland; and more generally, about treatment research;
- Their views on key omissions in the local and international knowledge base;

- What they perceived to be the key steps in moving the evidence base forward in Scotland; and
- Their views on the links between the evidence base and policy in Scotland.

The key findings from each of these stages are outlined below.

What are the evidence requirements of *The Road to Recovery*? There is strong and supportive evidence for the transition from models of acute care to recovery based on: 1) international evidence and extrapolations from the mental health field; 2) alcohol research; and 3) from a growing UK research interest in recovery from drug dependence. However, there remain many unanswered questions in a Scottish context relating to long-term changes to sustained recovery, the role of treatment and other forms of community intervention and engagement, and the catalysts and mediators of change. This will include variability in recovery pathways depending on problem severity and personal characteristics, as well as the recovery supports and recovery capital available. There are three areas that require significant research commitment - recovery-specific research; treatment and interventions; and prevention and public policy. The challenge is to build up sufficient human and research resource to allow these three areas to be linked to ensure that the innovations in recovery practice in Scotland are evidenced and brought to bear in ensuring that the recovery goals of the strategy are achieved.

What do we know about recovery? There is little UK-based research and the international evidence base on recovery is limited by three factors:

1) Much of the evidence is dated;
2) Much of it is based on alcohol rather than illicit drugs; and
3) Almost all the evidence originates from the United States.

Despite this, this review has found that some key conclusions can still be drawn from the existing evidence:

- Sustained recovery is the norm although the time to recover, and the pathways involved are highly individualistic. For this reason, a narrow, 'diagnostic' definition of recovery is not advisable.
- The best predictor of the likelihood of sustained recovery is the extent of 'recovery capital' or the personal and psychological resources a person has, the social supports that are available to them and the basic foundations of life quality, i.e. a safe place to live, meaningful activities and a role in their community (however this is defined).
- Barriers to recovery include psychological problems (mental illnesses and the absence of strengths, such as self-esteem and self-efficacy), significant physical morbidities (including blood borne viruses), social isolation and ongoing chaotic substance use.
- While structured treatment has a key role to play, it is only part of the support that most people will need. Ongoing support in the community is essential for the ongoing recovery journey and often includes mutual aid and other peer support.
- Recovery is not just about the individual, but impacts on families and communities.

Switching to a recovery model requires a fundamental change in the culture and attitudes of professionals and communities.

What is the evidence for treatment? There is a considerable history of cohort studies assessing the short-, medium- and in some cases the long-term outcomes of a range of mechanisms of delivery of drug treatment which consistently show significant improvements across a range of indicators, including health, offending, risk-taking, substance use and social functioning.

Differences in effectiveness between modalities of treatment (such as community detoxification, methadone maintenance and residential rehabilitation) have been less consistently reported in the evidence base, although the Scottish outcome study, DORIS undertaken between 2001 and 2004, reported low rates of sustained abstinence from stabilisation-focused community treatment in Scotland. The more recent USA outcome studies have switched focus from overall effects to the mechanisms of change with increased emphasis on the importance of service functioning and delivery, on therapeutic alliances and the process of client engagement and participation in treatment process. Other key findings have been that:

- There is a consistent evidence base supporting methadone substitution treatment in maintenance settings, based on meta-analytic data, but this requires not only prescribing but adequate psychosocial support and links to 'wraparound' care.
- Scottish outcome research has shown that while methadone maintenance leads to improved outcomes in a range of domains, it is associated with low rates of sustained abstinence.
- Continuity of care is a critical component of effective treatment systems, and there is a strong supportive evidence base around linkage to 12-step and other community 'aftercare' supports.
- There is an ongoing problem with psychosocial interventions – while there is a strong evidence base from trials, there is little evidence that these are routinely translated into everyday clinical practice.

The issue of 'technology transfer' is part of a recent transition to assessing what allows the evidence base to be applied in real clinical settings with increased focus on the structure of services and their organisational functioning.

What can we learn from other disciplines? Scotland has been at the forefront of the mental health recovery movement. The key underlying principles of recovery are:

- the empowerment of the person in recovery.
- focusing on the enabling role of the professional.
- a much greater role for family and community engagement in recovery.

These principles have been key drivers for changing the way that professionals engage with their clients and have required major shifts in professional cultures and workforce development.

From the evidence reviewed here and within the context of this review, there remain concerns (Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence, 2007) about the lack of 'hard' evidence in the mental health recovery movement and mental health recovery remains at an early stage in its knowledge base and practical implementation. Much of the evidence to date in this field has been drawn from personal experiences, and systematic analysis has been more limited.

Equally as important as the changing role of professionals and the empowerment of the person in recovery, is the increased role of communities as both a setting for recovery to occur and a foundation for supportive relationships and opportunities for vocational and personal growth, as well as a developmental platform for recovery. Finally, there are lessons to be learned from the criminal justice research field where the assumption is that desistance (or recovery) is the norm and that it is life transitions, rather than interventions, that will be part of a maturationally-based recovery (i.e. individuals will naturally move on from these behaviours without intervention). While all of these approaches necessitate caution, the common themes that they promote are the central role of self-empowerment, the centrality of the community rather than the clinic and the recognition of an ongoing and dynamic process of change.

What are the key findings of the literature review and what do these mean for policy? The analysis of published research papers largely supported the findings of the earlier reviews, with the most dominant themes emerging around recovery emphasising:

- There is clear support for effective engagement in recovery housing and in training and vocational support as parts of a recovery package of care.
- While there is some support for specific psychological or psychosocial interventions, there is increasing evidence that the context of treatment, in particular, the therapeutic alliance (the working relationship between the client and the worker or programme) and the level of client engagement, is an equally important predictor of treatment outcomes, with worker motivation and efficacy central to this effect.
- Effective continuity of care is essential with an increasing international evidence base around the benefits of 'assertive linkage' (active attempts by workers to ensure engagement rather than simply passing on contact details or addresses) to aftercare and community support and for the use of recovery management check-ups.
- There is a strong and consistent evidence base around the benefits of engaging in mutual aid and ongoing support.
- There is some supportive evidence for recovery in three key population groups – adolescents, offenders with drug problems and drug users with co-morbid mental health problems – but the evidence is more limited than in each of the other areas reviewed.

The key recovery finding from the review emphasises the importance of ongoing support after structured treatment, the positive outcomes associated with mutual aid and peer support in the community and the importance of assertive follow-up support

as aftercare. In Scotland, there is no adequate research or evaluation base on aftercare for drug treatment.

What did the key experts conclude? There was an overall consensus that a clear strategy is needed for developing an evidence base that will both support and test key aspects of *The Road to Recovery*. The summary below does not do justice to the considerable diversity of opinion and expertise that was expressed during these qualitative interviews. Some of the common views were that:

- There was general agreement that there has not been enough support for drug research in Scotland and that the local evidence base is poor as we are too reliant on international studies.
- There remain major limitations in what can be done with the local monitoring data, although this is likely to improve and there may be important lessons to be learned from the experiences of the National Treatment Agency (NTA) in England.
- Nonetheless, there were seen to be examples of innovation and good practice, but these frequently lacked the rigorous evaluation and dissemination to justify replication elsewhere.
- There were also concerns expressed about the culture of Scottish drug treatment and interventions, and a recognition that the implementation of a recovery model would not be possible without significant work done on workforce development and training.
- Key areas identified as needing further research were around long-term outcomes, the effectiveness of alternative medications to methadone (buprenorphine and suboxone), the effectiveness of community and residential rehabilitation, and technology transfer work on effective implementation of research.

So what are the conclusions? Recovery is a philosophical approach to addressing drug problems based on personal choice, empowerment and strengthening communities, and it also has a growing evidence base, which clearly demonstrates that recovery-focused approaches can augment and enhance treatment interventions, as well as maximising their benefits to families and communities. The review confirms the need for a more strategic, programmatic approach to developing the drugs recovery evidence base in Scotland. To ensure that the implementation of *The Road to Recovery* is informed by the best possible evidence, the authors suggest the following actions:

1. Introduce a Drug Research Forum under the auspices of the National Drugs Evidence Group.
2. Split the Forum's work into three areas: recovery-specific; treatment and interventions; and prevention and public policy. There are solid foundations for developing a treatment effectiveness programme of work in Scotland that should be linked to, but separate from, the more flexible, exploratory and innovative work around recovery, which in turn will build more on innovative practice and narratives of change.
3. Develop a key focus on the transitions to abstinence and the continuity of care in the course of recovery journeys with a significant focus on community and mutual aid groups.

4. Improve the understanding of treatment delivery and the 'technology transfer' of evidence within a framework of generating an improved evidence-based culture.
5. Improve our understanding of the benefits and costs of long-term prescribing and how to generate recovery communities within maintenance treatment services.
6. Task the forum with research prioritisation and negotiation with key bodies around sustainable funding support for research and broader evaluation and audit work within Scotland and as a player in international recovery and addiction work.
7. Develop appropriate collaborations and funding opportunities outside the addictions silo looking to the key areas of 'recovery gain' to evaluate and fund recovery-oriented activities.

What we are lacking in Scotland (as in the rest of the UK) is a clear evidence base about the long-term pathways to recovery and their impact on families and communities. The transition suggested within recovery perspectives to a developmental model necessitates a transition in both research and monitoring to a more longitudinal perspective that maps treatment and recovery journeys to sustained recovery (estimated as 5-7 years after achieving abstinence from ongoing street drug use), and that examines the treatment and support factors that precipitate that change. This also necessitates a switch in focus to a model that is focused less on the individual in isolation and more on the community and the family and so assesses outcomes in this wider context including the quality of life of children and partners and active engagement in local community affairs. What this will provide is a coherent model for testing and evaluating current practice; linking standard data monitoring to the development of a knowledge base; and developing a flexible and innovative research model that tests key aspects of implementation of *The Road to Recovery* and allows for a consistent mechanism for assessing the micro- and macro-impact of policy implementation in a systematic and evidence-based manner.

CHAPTER 1: INTRODUCTION

Research Project Overview

1.1 In May 2009, the Justice Analytical Services Division of the Scottish Government commissioned a review of the drugs' evidence base with the aim of establishing what we need to know to implement Scotland's National Drugs Strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*. The review was commissioned to support the aims of Scotland's National Drugs Evidence Group.

1.2 This report provides the evidence which will help the National Drugs Evidence Group make recommendations to Scottish Ministers about where the drugs evidence base is already robust, the lessons that can be drawn from the evidence base, as well as the further research and information priorities required to inform the delivery of the national drugs strategy. Additionally it helps provide the basis for a more integrated, considered and longer-term approach to commissioning and conducting research and analysis in this field in Scotland.

Background

1.3 Scotland's national drugs strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem,*[1] was launched in May 2008. The strategy focuses on recovery and reinforces the message that services should support people to move towards a drug-free life as active and contributing members of society. *The Road to Recovery* also emphasises the importance of evidence-informed drugs policy and practice. In order to deliver real change for people who are affected by drug use, it is essential that drugs policy is informed by what works, how it works and why.

1.4 As such *The Road to Recovery* committed to establishing the National Drug Evidence Group in order to advise Scottish Ministers on the evidence priorities required to deliver the new drugs strategy. By overseeing the development of an integrated evidence plan the group is contributing to strengthening the knowledge base for the prevention, identification, management and treatment of drug misuse in Scotland.

1.5 The strategy acknowledged that in some areas good evidence is available to guide decisions, but in other areas the research evidence and data could be improved in order to develop further our understanding of the Scottish drug-using population, the factors affecting people's substance misuse, the harms experienced and the most effective interventions in education, prevention and treatment.

1.6 There is no formal mechanism for identifying research and information priorities around drug misuse in Scotland. New drug-related research in Scotland might be commissioned by a number of bodies including the Scottish Government,

[1] Scottish Government (2008) *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, Edinburgh: Scottish Government, http://www.scotland.gov.uk/Publications/2008/05/22161610/0, (accessed 4 March 2010)

the Chief Scientist Office, the NHS's Information Services Division (ISD) Scotland, NHS Health Scotland and research grant bodies, such as the Joseph Rowntree Foundation, the Economic and Social Research Council, the Esmée Fairbairn Foundation and the Robertson Trust. There is a need to explore opportunities for pooling together resources more effectively, assessing capacity in the field and being more strategic in funding research and analysis.

1.7 This review focuses on what the existing drugs' evidence base tells us in relation to the priorities of *The Road to Recovery*. However, the work is also intended to have a wider impact and allow for a more integrated, considered and long-term approach to addressing data requirements and commissioning and conducting research and analysis. In addition, as a key resource setting out existing evidence and future needs, it is intended to facilitate better knowledge exchange with other experts in the substance misuse field and associated areas.

1.8 A number of recent policy and structural developments have occurred that make a comprehensive review of the evidence opportune. These developments have included a number of Scottish Government policies and actions with a direct or indirect relevance to drugs, e.g. *The Early Years Framework*[2], *Changing Scotland's Relationship with Alcohol: A Framework for Action*[3] and *Towards a Mentally Flourishing Scotland*[4]. In addition, as prioritised in the final chapter of *The Road to Recovery*, the environment in which local partnerships tackling alcohol and drugs misuse operate has evolved with an increased emphasis on outcomes-focused planning. A New Framework for Local Partnerships on Alcohol and Drugs[5] was launched in April 2009.

Aims & Objectives

1.9 The main aim of this review was to show where the evidence base is already strong, what the evidence tells us and what we still need to know in order to implement the drugs strategy.

1.10 Specifically, the objectives of the programme of work were to:

- Map the evidence requirements of *The Road to Recovery*.
- Review the findings of existing evidence, assess the quality and identify key gaps in the literature.
- Synthesise evidence of effectiveness (including cost-benefit analysis) especially in relation to what works in drugs treatment in Scotland, the UK and further afield.
- Identify and assess existing datasets with an appraisal of their potential for further analysis and linkage.
- Frame the gaps in good quality evidence required to implement the Drugs Strategy.
- Pinpoint potential providers of evidence and funders that might help to fill those gaps.

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[2] http://www.scotland.gov.uk/Topics/People/Young-People/Early-years-framework [accessed 4th March 2010]

[3] http://www.scotland.gov.uk/Publications/2009/03/04144703/0 [accessed 4th March 2010]

[4] http://www.scotland.gov.uk/Publications/2009/05/06154655/0 [accessed 23the April 2010]

[5] http://www.scotland.gov.uk/Publications/2009/04/23084201/0 [accessed 4th March 2010]

- Report on the review to the National Drugs Evidence Group.
- Prepare a *draft* framework on current and future research and information priorities for discussion by the National Drugs Evidence Group and the Scottish Government.

Overview of Methods

1.11 The aim of the research was to review the evidence base, building on existing reviews, to assess the quality of the evidence available and to identify the evidence gaps specific to *The Road to Recovery*. It also looked to generate a logical method of mapping the evidence requirements of *The Road to Recovery* in research terms, to assess the applicability of evidence to the Scottish context, accounting for other levels of evidence (including unpublished and ongoing work around recovery) and to test this within a framework that utilised existing data sources, data systems and the views of key evidence experts in Scotland.

1.12 While the core of the project involved a literature review combined with a search of local knowledge and evidence, this was embedded within an open and iterative research process that set parameters for the review in terms of the local policy and monitoring framework and that enabled a process of consultation around the preliminary findings and recommendations. The aim was to generate a methodologically robust and replicable systematic search approach, where relevant, and to test this in the context of an expert review process, which was also conducted with research rigour around mapping knowledge and expertise as a developing and evolving process. For this reason, the design involved a number of stages that can be characterised in two broad phases:

1. Review and systematic search of documentary sources.
2. Testing the resulting findings in the local context of Scottish policy and practice.

Key Evidentiary Issues

1.13 Throughout *The Road to Recovery*, reference is made to key evidentiary statements. One of the key aims of this report is to highlight these issues and to provide assessment and comment on the level and strength of evidence underpinning these. This approach has two advantages: first it sets out the scope of the study; and secondly it provides an evidence checklist. A number of these issues are addressed in different chapters within this report and, where this is the case, we have signposted relevant connections.

CHAPTER 2: METHODS

2.1 The methodology for this study was designed to collect evidence and information in a sequential and logical manner. It allows a broad scope for learning about approaches to recovery from other countries and other fields as well as having a clear focus on evidence of treatment effectiveness and the emerging research needs for Scotland.

Summary of Study Methods

2.2 Table 2.1 summarises the four distinct phases to this study. A fuller description of these methods is provided in Paragraph 2.3 to Paragraph 2.18.

Table 2.1: Summary of study methods

Phase 1	**Method**
Mapping of evidence	Outline of the key evidence requirements of *The Road to Recovery* and initial analysis of relevant research reviews conducted in Scotland, other parts of the UK and internationally.
	Conduct an initial analysis of core policy documents and synthesise for their evidentiary foundations.
Phase 2	**Method**
Supplementary reviews of evidence	Conduct a review of national and international literature on recovery
	Conduct a review of national and international literature on treatment effectiveness
Phase 3	**Method**
Review of literature	Basic search terms were 'recovery', effectiveness' and 'outcomes' linked to each of the domains generated from *The Road to Recovery* analysis, the search of policy documents and the authors' cumulative awareness of relevant documents.
	A review of the evidence was conducted in each of these areas narrowing the search by English language, last 20 years and published in peer reviewed journals.
Phase 4	**Method**
Field testing of preliminary analysis	Conduct initial field testing of preliminary analysis and synthesis with advisory group and other expert sources identified.
	Conduct mapping of government and other data sources.
	Conduct mapping of the 'grey literature.

2.3 **Phase 1**: Conducting the mapping exercise of *The Road to Recovery* and the links to relevant evidence. This is linked to a contextual and policy framework, using *The Road to Recovery* as the starting point.

2.4 Two main steps were involved:

- Outline of the key evidence requirements of *The Road to Recovery* and initial analysis of relevant research reviews conducted in Scotland, other parts of the UK and internationally.
- Conduct an initial analysis of core policy documents and synthesise for their evidentiary foundations.

2.5 All primary and secondary references were identified, obtained, logged and stored in Mendeley online secure research database. In essence, this involved tabulating the key evidence sources explicitly referred to in *The Road to Recovery* and identifying their evidentiary foundations – this included published research papers and summaries, and key policy documents (from the addictions field and from other related areas, such as child protection and criminal justice) with reference to the evidence base that is applicable from each of these areas.

2.6 The review of the policy framework underpinning *The Road to Recovery* was conducted as a synthesis rather than analytically to ensure there was no misinterpretation of information, and that the 'output' of this process was a set of summary tables of core documents and a 'trail' of the evidence included. Therefore much of the synthesis provided for the review is direct quotation, with an attempt to minimise interpretation or inference from the research team. Relevant information has been summarised and comments made about relevance to recovery (on an individual, service and at a systems level), as well as briefly identifying the possible technology transfer issues. The core technology transfer questions have been:

- Is this relevant to the drugs field?
- Is this relevant to recovery?
- Is this relevant to Scotland?
- Are there other issues around applicability?

2.7 The key documents that are referred to in *The Road to Recovery* strategy are discussed in Chapter 6 and a summary analysis of each of these documents is provided in Appendix 1, giving an overview of their relevance to the recovery agenda, to Scotland and to issues of effectiveness and outcomes.

2.8 **Phase 2**: Supplementing the evidence mapping process by conducting two specific reviews of evidence – an international summary of what we know about recovery and a summary of the evidence base around treatment effectiveness and treatment outcomes specific to the drugs field. These are presented as Chapters 3 and 4 respectively in the report.

2.9 A further trawl was conducted to review what is known from other parallel fields, particularly mental health, that can be used to provide guidance around implementing the tenor and principles of *The Road to Recovery*. This is provided as Chapter 5 in the report.

2.10 **Phase 3**: Conducting a systematic trawl of published evidence with a search extended by the policy document analysis and synthesis of key terms and known documents.

- Basic search terms were 'recovery', effectiveness' and 'outcomes' linked to each of the domains generated from *The Road to Recovery* analysis, the search of policy documents and the authors' cumulative awareness of relevant documents.
- A review of the evidence was conducted in each of these areas narrowing the search by English language, last 20 years and published in peer reviewed journals.

2.11 There were four key steps involved in the literature review phase:

- Preliminary search
- Re-defining of search terms
- Review by citation
- Review by abstract.

2.12 The preliminary search strategy for the literature review envisaged a three level search as detailed in Table 2.2.

Table 2.2: Systematic literature search strategy

Substance Domain	**Link Domain**	***Road to Recovery* theme**
Drug Drug misuse Drug abuse Drug dependence Substance misuse Substance* Drug* Heroin Crack cocaine Cocaine Amphetamines Methadone	Recovery Outcomes Effectiveness	Treatment Intervention Prevention Education Criminal Justice Prison Families Hidden Harm Getting it Right for Every Child

2.13 The research team undertook searches of Ovid MEDLINE, All EBM reviews, EMBASE and PsycINFO,[6] with limitations of English only articles written after 1990. Initial searches of all the terms under the SUBSTANCE domain combined with one or more of the LINK DOMAIN items yielded over 100,000 results.

2.14 The terms 'drug', 'drugs', 'substance' and 'substances' in the SUBSTANCE domain were removed as the search results were not specific to drug misuse and included papers on therapeutic pharmaceutical drugs. The remaining terms were combined with the LINK DOMAIN terms to further focus the search. This resulted in a more relevant set of references, i.e. relevant to drug misuse and dependence, so it was decided to exclude 'drug', 'drugs', 'substance' and 'substances' from all future searches. Following several further test searches, the research team combined

[6] Using Knowledge Network (formerly known as the NHS E-Library), http://www.knowledge.scot.nhs.uk/home.aspx, [accessed 4 March 2010]

some of *The Road to Recovery* theme domains since these are inter-related and form natural groupings. This allowed new three level searches to be undertaken according to Table 2.3.

Table 2.3: Linking the search to the recovery agenda

Substance domain	Link domain	*Road to Recovery* theme
Drug misuse Drug abuse Drug dependence Substance misuse Heroin Crack cocaine Cocaine Amphetamines Methadone	Recovery Outcomes Effectiveness	Treatment and Intervention Prevention and Education Criminal Justice and Prisons Families (Hidden Harm and Getting it Right for Every Child)

2.15 Having undertaken a new search using the three domains above, results were imported into Endnote software and any duplicate articles removed. Table 2.4 shows the results of the second stage search.

Table 2.4: Second stage search yield

Subject	Number of articles
Prevention and Education	1030
Treatment and Intervention	811
Families	565
Criminal Justice and Prisons	118
Total	2524

2.16 In order to further reduce this to a set of core articles the citations to all 2524 articles were sourced and stored in Endnote databases. The citations were reviewed by the research team, based on their relevance to the domains of treatment outcomes, treatment effectiveness and recovery. Further inclusion/exclusion parameters were applied. Thus, articles which assessed only acute effects of interventions, were primarily epidemiological or which had no measures that related to long-term quality of life, sobriety or citizenship components (such as employment, family functioning and stability of living circumstances) were excluded.

2.17 One of the limitations encountered in this process was that the term 'recovery' has a wider, generic meaning across health and social care and in common usage than that adopted within *The Road to Recovery* document. This created difficulty when attempting to identify relevant articles using 'recovery' as a key search term at the same time as trying to ensure that the search was focused and relevant to the task in hand. The abstracts of all remaining articles were reviewed in order to ensure relevance to the subject area. A small number of papers were removed at this stage, predominately because their relevance to recovery was tenuous.This was then followed by a review of full articles. This was the final elimination process. This excluded papers which were not appropriate but where the abstract had not provided enough relevant information to make this decision. Using this further filtering process

a final set of research articles was established. This is set out by topic area in Table 2.5. These articles provide the evidentiary base for the literature review.

Table 2.5 Final search yield

Subject	Number of Articles	
	Initial	Final
Prevention and Education	1030	37
Treatment and Intervention	811	79
Families	565	62
Criminal Justice and Prisons	118	27
Total	**2524**	**205**

2.18 The processes involved in Phase 3 are set out in Figure 2.1.

2.19 **Phase 4**: Initial field testing of preliminary analysis and synthesis with advisory group and other expert sources identified; initial mapping of government and other data sources; initial mapping of the 'grey literature'.

2.20 This phase represented the transition from the documentary phase of the project to the 'testing' phase where the team switched from collation and analysis of original source materials to key informants and unpublished data sources. The aim of the interview phase of the project was to test the applicability of what had been collected to date and to identify other key sources of information. Those other key sources included:

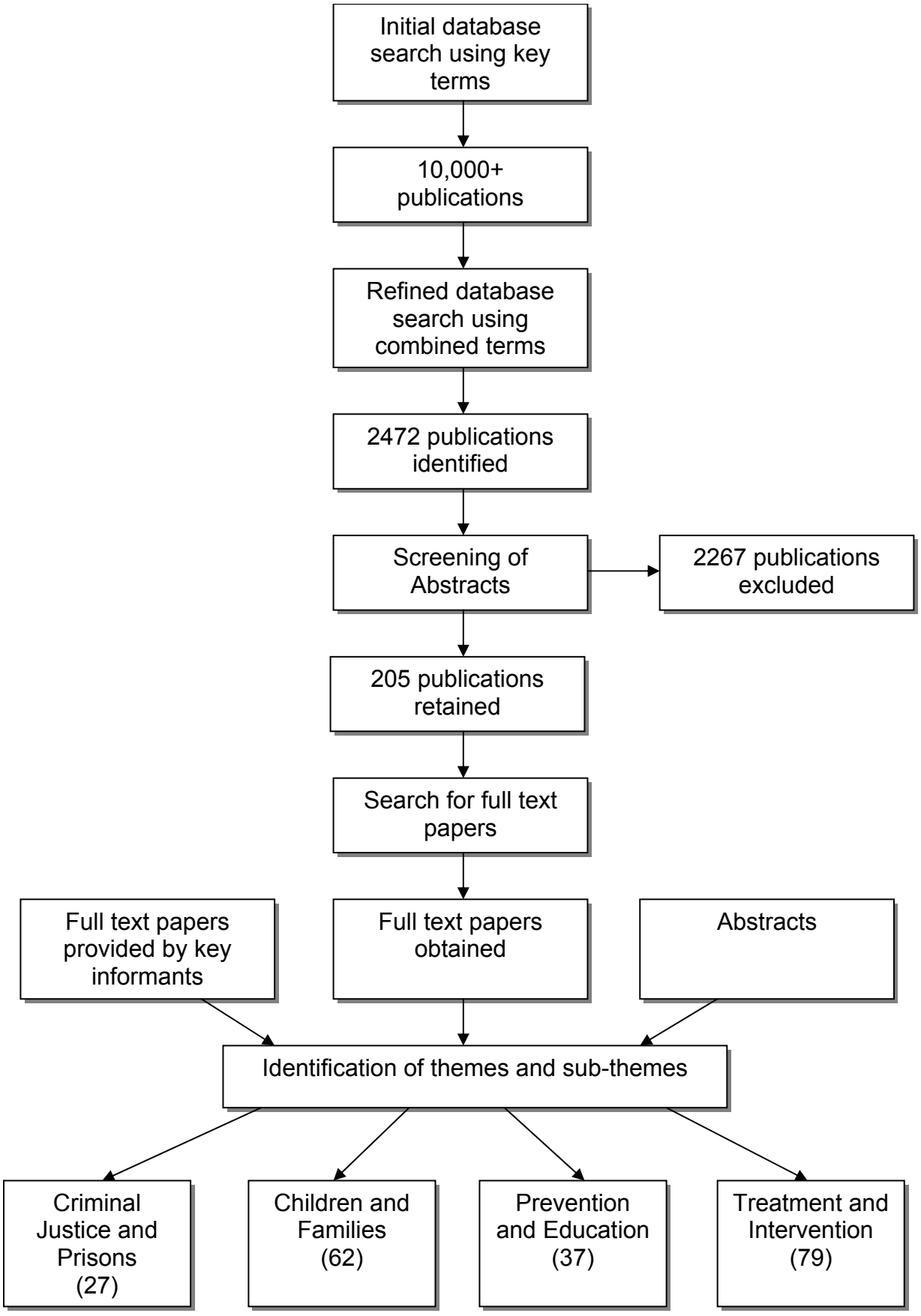
- Routine data collection sources (e.g. information held at NHS NSS Information Services Division, ISD, Scotland[7]).
- Recently published or 'in press' academic research that may not have been picked up in the literature review.
- 'Grey literature' sources.
- Audits or evaluations that have not been published relating to the three core domains of treatment effectiveness, treatment outcomes and recovery.
- The identification of wider sources by key informants.

2.21 Key experts were accessed using the following groups:

1. Research advisory group members (including Government social researchers and policy advisors)
2. Members of the National Drugs Evidence Group
3. Practitioners
4. Other key experts as recommended in the first wave of interviews

[7] Information Services Division (ISD) Scotland is part of NHS Scotland and is Scotland's national organisation for health information, statistics and IT services, found at http://www.isdscotland.org/isd/CCC_FirstPage.jsp [accessed 4th March 2010]

Figure 2.1: Flow Chart Summarising processes of evidence review strategy



CHAPTER 3: WHAT IS THE RECOVERY EVIDENCE BASE?

3.1 The aim of this chapter is to review the international evidence for key areas of recovery and to consider these in terms of an evidence base for moving towards a recovery philosophy in treatment systems. This chapter was compiled by William White and David Best and reviews the international evidence around recovery. It starts by reviewing the discussions around the meaning of recovery and the evidence around prevalence and predictors of recovery. The second section expands out to look at experiences of recovery in communities and what the implications of recovery are for localities in terms of treatment and recovery-oriented systems of care.

3.2 The majority of the chapter reviews the evidence around recovery in terms of the role of treatment services and the need for effective linkages to post-treatment support. This has been structured so that it broadly follows the client's 'treatment journey' and is sequential, focusing on the relationship between recovery communities and structured treatment at different stages of the journey. All of the material included here is based on peer-reviewed research (albeit some of it summarised in review articles and monographs), and where this evidence does not come from illicit drug using populations, this has been made clear in the text. Finally, the chapter assesses the limited evidence base for recovery in the UK within the context of drug misuse.

3.3 The summary below identifies what the evidence currently tells us and highlights where some of the key omissions are from an evidence perspective that would be relevant to drugs recovery in a Scottish context.

Summary: Key Findings from the Recovery Literature

1. There is a wide range of pathways to recovery and the evidence illustrates the importance of individuals discovering their own path. This is consistent with the individualisation agenda identified for mental health by the Scottish Recovery Network and in the personalisation component of the recovery model outlined in Scotland's national drugs strategy - *The Road to Recovery*.
2. Recovery stabilisation does not happen quickly. For alcohol users, it will typically take 4 to 5 years, and there is evidence that it will generally take longer in opiate users, with estimates suggesting a recovery journey of 5 to 7 years.
3. The best predictors of effective recovery are the extent of recovery capital, or in other words, the personal and social resources that a person has to call on.
4. In contrast, barriers to recovery include early onset and increased complexity of problems, as well as co-morbid physical and mental health problems, including ongoing alcohol and prescription drug use.
5. Treatment has a key role to play in recovery, although the evidence suggests that effective co-ordination of professional treatment and sustained community support will be most effective.
6. Effective recovery not only benefits the individual, but also their family and their community. The evidence shows that when recovery is sustained beyond treatment, it can have a positive impact on the psychological health of the children of parents in recovery; and there are grounds for suggesting that this will be a mediating factor to aspirations and achievements in young people.

7. Although the UK evidence base is limited, and much of the evidence is based on alcohol research, there are increasing grounds for believing that recovery is a viable and empirically established phenomenon for drugs.

What Works for Recovery as a Personal Journey? Foundational Principles

Recovery Definition

3.4 In *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* (Scottish Government, 2008) recovery is defined as:

> *'a process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society.'*

3.5 The report went on to state that:

> *'recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment….an aspirational and person-centred process' (Scottish Government, 2008, p23)*

3.6 *The Road to Recovery* definition acknowledges the individuality of the recovery process, and the recommended strategy reflects explicit parallels with the success of the Scottish Recovery Network in advancing the cause of recovery in the mental health arena in Scotland.

3.7 In the same year, the UK Drug Policy Commission convened a meeting of senior UK practitioners and academics, former drug users and family members to develop a UK 'vision' of recovery. Recovery was characterised as a process of:

> *'voluntarily sustained control[8] over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' (UK Drug Policy Commission, 2008, p6)*

3.8 The report emphasises the range of routes to recovery and also suggests that this includes 'medically-maintained abstinence' (UKDPC, 2008, p6).

3.9 In the USA, the Betty Ford Institute Consensus Panel (2007, p222) defined recovery as:

> *'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship.'*

3.10 The Consensus Panel further detailed the meaning of sobriety by explicitly stating that:

[8] Voluntary sustained control has generally been interpreted to include medication-assisted as well as abstinent recovery

'formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other non-prescribed drugs would meet this definition of sobriety' (p224)

3.11 Although this definition permits ongoing prescribed drug use, it sets a high threshold around 'controlled drinking' and occasional use of cannabis and other illicit drugs – both of which would be excluded by this definition. The Panel further differentiated the stages of recovery as 'early sobriety' (the first year), 'sustained sobriety' (between one and five years), and 'stable sobriety' (more than five years).

3.12 Through this collective definitional work to date, recovery from a substance use disorder has been characterised by three core dimensions of change (White, 2007):

- remission of the substance use disorder;
- enhancement in global health (physical, emotional, relational, occupational and spiritual); and
- positive community inclusion.

3.13 Recovery experiences can vary in the degree and scope of change. These variations span full recovery (i.e. the above three criteria of recovery are met for a defined period of time), partial recovery (decreased frequency/intensity of problems; one or two but not all three recovery criteria met) and amplified recovery (full recovery plus dramatically enhanced levels of functioning far superior to pre-addiction levels, White & Kurtz, 2006). The varying depth and span of change in recovery is evident across diverse pathways (spanning secular, spiritual and religious frameworks of personal transformation) and personal styles of recovery (see later discussion).

Recovery and Help-Seeking Behaviours

3.14 Those seeking specialist addiction treatment differ markedly from the larger pool of individuals experiencing and naturally resolving alcohol and other drug (AOD) problems within the community (Dawson, 1996). These differences constitute the 'two worlds' of alcohol and other drug problems (Storbjork & Room, 2008). Individuals with low to moderate AOD problem severity and moderate to high recovery capital (i.e. internal and external assets that can be mobilised to initiate and sustain recovery) often resolve AOD problems on their own through recovery supports within their family or community or through brief non-specialist professional intervention. This style of problem resolution is well-documented in the early research on 'spontaneous remission' and 'natural recovery' (Biernacki, 1986; Tuchfeld, 1981), and the more recent work by Cunningham and colleagues (2000).

3.15 Compared to persons experiencing and resolving AOD problems in community samples, adults and adolescents entering specialist addiction treatment are distinguished by:

- greater personal vulnerability (e.g. family history of substance use disorders, maltreatment as a child, early pubertal maturation, early age of onset of AOD

use, conduct disorder during early adolescence, substance using peers, and greater cumulative lifetime adversities);
- greater severity of use (longer duration of use, dependence, polysubstance use, opiate dependence) and intensity (frequency, quantity, and high-risk method of ingestion and high-risk using contexts) and greater alcohol or drug related consequences;
- higher rates of developmental trauma, post-traumatic stress disorder, and co-occurrence of other medical/psychiatric illnesses;
- greater personal and environmental obstacles to recovery; and
- less recovery capital (White and Cloud, 2008).

3.16 In other words, the treatment seeking population is characterised by typically lower levels of personal and social capital and by greater levels of vulnerability. The need for addiction treatment, particularly prolonged or repeated treatments, is often a proxy for social and cultural marginalisation and the need for sustained guidance into full participation in communities and society (Storbjork & Room, 2008). Natural recovery is the predominant pathway of resolution for transient substance-related problems and less severe substance use disorders, whereas, professionally-directed treatment with sustained recovery support is the dominant pathway of entry into recovery from substance dependence (Dawson, et al, 2006; Cunningham et al, 2000; Price et al, 2001).

Natural Recovery

3.17 Granfield and Cloud (2001) differentiated the turning point that led to stopping drug use from the need for ongoing strategies to sustain abstinence, with the latter often involving alternative activities, changing social networks and increased reliance on family and non-using friends. As Granfield and Cloud (2001) have found:

> *'those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment'.*

3.18 Within this context, social capital includes the social supports that the individual can draw on, like family and friend support, but will also include the commitment to standard societal values. Blomqvist (1999) reported data on a comparison of recovery in drug and alcohol users, finding that drug users typically had more pre-resolution negative events than alcohol users (particularly around legal and psychological factors) and that these strains persisted over the course of the recovery journey.

3.19 Nonetheless, Blomqvist also found that three-quarters of the sample also reported at least some positive factors in their reasons to stop, such as finding a new partner. Blomqvist concluded that natural recovery was more likely to be associated with a combination of positive and negative motives, while treated recovery was more typically associated with hitting 'rock bottom'. Blomqvist (1999) has argued that the allocation of resources and opportunities in life will shape the likelihood of recovery journeys and the options available to people. In a study conducted in Scotland, McIntosh and McKeganey (2000) discussed the need for a change in self-perception and identity and talked of the need to 'repair' the user's identity, based on

interviews with 70 individuals in recovery. At the time of the interviews, the individuals' average age was 29, they had a using career of around 9 years and had not used for an average of four years. McIntosh and McKeganey also emphasised the importance of differentiating between the factors associated with striving for and achieving initial recovery and factors associated with sustaining that recovery journey. They found that avoidance factors, such as being tired of the lifestyle and physical health problems, typified desistance efforts while approach factors, such as family and jobs, were more likely to predict sustained recovery.

3.20 An alternative approach to mapping natural recovery involves the use of population survey methods, either by including sections on addiction experience and history in omnibus-type population surveys, or by conducting door-to-door community assessments specific to mental health and addiction, such as the Epidemiological Catchment Area survey. Sobell, Campbell and Sobell (1996) reported rates of 75% and 77% recovery without formal help in former problematic drinkers. In a further Canadian study based on population survey data, Cunningham (2000) assessed recovery from a range of substances described by the sample as problematic at some point in their lives and reported that the use of any formal treatment ranged from 43.1% for cannabis to 90.7% for heroin, with 59.7% of cocaine users seeking formal treatment at some point in their recovery journeys.

3.21 Bischof et al (2001) analysed general population surveys in northern Germany to compare current alcohol-dependent drinkers with remitters who had sought no formal help and found that the remitters had a later onset of dependence and had fewer years of dependent drinking, but higher average daily alcohol consumption. The authors also found that the remitters were more likely to live in a stable relationship and be more satisfied with work and with their financial situation.

Recovery Prevalence and Predictors

3.22 Recovery is the rule rather than the exception: most (50% or more) people with significant AOD problems (meeting diagnostic criteria for a substance use disorder) will eventually resolve those problems (see White, 2008a for review, based on a combination of natural recovery studies, and long-term substance use follow-up studies discussed below). The prognosis for long-term recovery varies markedly by degree of problem severity and by personal, family and community recovery capital (White and Cloud, 2008; Granfield & Cloud, 1999, 2001). There are two clinically important corollaries to this statement: (i) the earlier the age of onset of problem development, the longer the addiction career before recovery stabilisation; and, (ii) the earlier the onset of first treatment (by age and years of use), the earlier the onset and stabilisation of recovery (Dennis et al, 2005). The scales of eventual recovery or sustained addiction may be tipped as much by community recovery capital as by intrapersonal factors (White, 2009b).

Pathways and Styles of Recovery

3.23 There are many (secular, spiritual and religious) pathways of long-term recovery. Pathways constitute broad organising/sense-making frameworks for change. There are also varied styles of recovery within these broad pathways (White & Kurtz, 2006). Styles of recovery encompass variations in:

- Goals (abstinence versus stable, long-term moderation),
- Personal identity (recovery positive, recovery neutral, and recovery negative),
- Degree of affiliation with others in recovery (this will include the extent of social learning and engagement in shared activities, as well as the coherence of views and beliefs about recovery),
- Type of resources mobilised for recovery support (solo recovery, peer-supported recovery, professionally-supported recovery, medication-supported recovery), and
- The temporal aspects of the change process, e.g. transformative change, incremental change or drift (White & Kurtz, 2006).

3.24 Pathways and styles of recovery also vary by gender, across the life cycle (age of recovery initiation) and across cultural contexts (White, 2006a). These pathways and styles are mirrored by different approaches to addiction treatment and peer-based recovery support. Responses to all professional treatments and peer-based recovery support structures include persons who optimally respond, partially respond, or fail to respond (Morgenstern et al, 1996). There may also be individuals whose symptoms worsen following helping/support interventions. In medicine, these latter effects are referred to as iatrogenic illness—clinical deterioration caused by the treatment intervention (Moos, 2005), although this may also be indicative of a personal downward spiral that treatment is not able to arrest. Thus, in the UK, there is a small proportion of the sample studied by Skodbo and colleagues (2007) whose offending and drug use actually increased after the engagement with treatment in the criminal justice system although it is not possible to attribute this causally to the effects of the treatment. One possible explanation suggested for this was poor levels of treatment engagement and delivery.

Recovery Initiation

3.25 Multiple factors can interact to facilitate recovery initiation. These can take the form of push (avoidance) factors and pull (approach) factors or constitute a process more aptly described as drifting out of addiction and into recovery (Granfield and Cloud, 1999). Push factors include crises in personal identity, family and significant other concerns, health concerns, economic concerns, legal troubles, fear of future consequences, and the decrease in positive drug experiences. Pull factors include exposure to positive recovery role models, family and social support, new opportunities, windows of opportunity for lifestyle change (e.g. relocation, job change), and emergence of new beliefs (e.g. religious conversion) (Bess et al, 1972). Recovery initiation involves reaching a tipping point in the interaction between these push and pull factors—what Baumeister (1996) depicts as the 'crystallisation of discontent' and White (1996) describes as the 'synergy of pain and hope'.

3.26 The recent growth in peer-based recovery support services as an adjunct or alternative to addiction treatment is based on the belief that exposure to the personal stories and lives of people in recovery can serve as a powerful catalyst of personal transformation for people suffering from severe AOD problems, and can form the basis of important social learning and reinforcement of recovery messages and values. Peer-based recovery support services can also play a significant role in eliminating or minimising the obstacles to treatment participation and recovery

initiation via motivational priming, education about treatment and recovery, logistical support (e.g. transportation, child care, recovery-conducive housing), assistance in reconstructing social relationships, mobilising family support and countering any efforts to sabotage recovery initiation, and coaching to counter social stigma related to treatment participation (White, 2009a; Dennis et al, 2009).

Stages of Recovery

3.27 There is a growing body of scientific literature positing stage theories of addiction recovery (DeLeon, 1996, 2007; Frykholm, 1985; Klingemann, 1991; Prochaska et al, 1992; Shaffer & Jones, 1989; Waldorf, 1983; Waldorf et al, 1991). These studies suggest that:

- Addiction recovery, like the active process of addiction, is often characterised by predictable stages and milestones;
- The movement through the stages of recovery is a time-dependent process;
- Within each stage of recovery are developmental tasks, skills to be mastered, certain perspectives to be developed, and certain issues to be addressed before movement to the next stage can occur;
- Treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent within each individual's current stage of recovery; and
- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilised in another stage of recovery. The greatest risk may be around detoxification at the wrong stage of recovery and without the necessary personal and social capital to sustain abstinence (White and Cloud, 2008).

3.28 When research on recovery stages is viewed as a whole, four broad stages of recovery are evident:

1) Pre-recovery problem identification and internal/external resource mobilisation (destabilisation of addiction and recovery priming);
2) Recovery initiation and stabilisation;
3) Recovery maintenance; and
4) Enhancements in quality of personal/family life in long-term recovery and across the personal/family life cycle.

3.29 One of the most consistent conclusions drawn from studies on the stages of recovery is that those influences that later sustain recovery ('maintenance factors') are different from those factors that serve to initiate early experiments in recovery ('triggering mechanisms') (Humphreys et al, 1995). In the study of UK recovery reported by Best and colleagues (2007), the focus at the point of desistance was typically around maturing out factors and physical or psychological health symptoms, and the maintenance of recovery was more commonly around social factors to do with families and peer support.

Zones of Action and Experience in Recovery

3.30 Recovery from severe AOD problems involves completion of key developmental tasks across five spheres of action and experience. These spheres include:

- **Physical**, e.g. safe and secure shelter; detoxification and management of drug hunger; avoiding/addressing secondary drug dependence; resolving addiction-related and co-occurring health problems (including transition to alcohol dependence or the use of prescription of over the counter medications); re-established rituals of self-care related to nutrition; sleep and hygiene; and, managing anhedonia.
- **Psychological**, e.g. weakening the addiction-sustaining defence beliefs; developing drug-free coping strategies; emotional catharsis; managing emotional ambivalence about recovery (grieving loss of drug and drug-focused relationships); developing techniques to respond to high-risk (of relapse) situations; tempering other potentially excessive behaviours (e.g. food, sex, work, money); initial story reconstruction. This will also involve the construction of psychological building blocks such as self-esteem, self-efficacy and a positive identity that are essential for recovery growth.
- **Spiritual/life meaning and purpose**, e.g. experiencing hope; drawing meaning from having survived death; experiencing connection to previously hidden resources within and outside the self; experiencing a sense of rebirth; daily rituals of self-reflection; experiencing breakthroughs in self/world-perception.
- **Relational**, e.g. re-negotiating relational roles and rules; managing intimacy and sexuality in a drug-free state; reaffirmation of key family rituals; re-embracing and redefining parental responsibilities; disengaging from pathology-bonded relationships; building a sobriety-based support network; cultivating recovery role models; helping others and community. There is a strong link to the agenda set by Hidden Harm and Getting it Right for Every Child (see Appendix 1) that link the relational part of recovery to the broader agenda of ensuring that recovery is focused on families and communities and not only on those experiencing recovery.
- **Lifestyle reconstruction***,* e.g. shedding language, dress, symbols, music and other trappings from the culture of addiction; disengaging from criminal enterprises; establishing a new relationship with work and money; resolving legal problems; restructuring daily rituals; developing drug-free leisure activities (White, 1996).

3.31 There is a limited evidence base about the sequencing and order of these changes, but they will be individual and will depend on contextual factors, as well as variations in recovery capital and personal resource. The evidence base in Scotland, in particular, is extremely limited but a range of online resources are becoming available (e.g. Wired In website[9] and the Scottish Drugs Recovery Consortium). These have the potential to provide the anecdotal foundations and community supports for recovery that may form the foundations for more formal research and evaluation. Rather than being a linear process, work on the tasks within each zone waxes and wanes over the course of long-term recovery (White, 1996). Persons

[9] http://wiredin.org.uk [accessed 5th March 2010]

seeking recovery have, for many years, looked to others in long-term recovery to offer guidance through these key developmental tasks (White, 2009a), providing a core form of social learning.

Cultures of Addiction and Recovery[10]

3.32 Individuals can be as dependent upon a culture of addiction—its language, values, roles, rituals, and relationships—as they are on the drugs that form the centrepiece of these cultures. The language of addiction as a 'chronic, relapsing condition' that permits no escape generates in workers and clients alike a pessimistic model for treatment that can become a self-fulfilling prophecy. Such cultures have been extensively described in the early ethnographic literature on addiction (Agar, 1973; Preble & Casey, 1969; Spradley, 1970; Waldorf, 1973). Elaborate cultural rituals can also surround the recovery experience, including rites of passage such as graduation ceremonies and celebrations of sobriety birthdays. The transition from addiction to recovery is often a journey from one culture to another, each with its own distinct trappings (e.g. language, values, symbols, institutions, roles, relationships, and rituals of daily living; White, 1996).

Common Elements across Recovery Pathways

3.33 There is a growing appreciation for the variety of recovery experiences, but there are also common themes and elements shared by these diverse pathways and styles of recovery. Such common elements include:

- Crisis (threat/opportunity forces re-evaluation of person-drug relationship).
- Discovery (of previously hidden resources within or beyond the self).
- Commitment ('Sobriety Priority').
- Rigorous self-evaluation (e.g. 'fearless and searching moral inventory').
- Reframing within a new world view (the once revered drug is now personally stigmatised).
- Confession (honest disclosure about oneself and one's past).
- Story/identity reconstruction (the stigmatised drug is now embedded in a new life story and a new set of values) and storytelling.
- Participation in a community of shared belief (e.g. secular, spiritual, or religious recovery support fellowships) for all but acultural styles of recovery.
- Lifestyle reconstruction (reconstruction of relationships and daily rituals, e.g. changes in 'people, places and things').
- Restitution (making amends for past injury to others).
- Service (extending help to others).
- Life meaning and purpose (addiction recovery is integrated into a broader vision and mission for one's life).
- Above changes embedded in daily rituals of recovery maintenance: centering rituals, mirroring rituals, acts of self-care, acts of service (White, 1996; Zemore et al, 2004).

[10] Excerpted from White (2009a)

Recovery and Social Support[11]

3.34 The resolution of severe alcohol and other drug problems is mediated by processes of social and cultural support (Brady, 1995; Laudet et al, 2006; Longabaugh et al, 1993; Spicer, 2001). Both general and abstinence-specific social support influences recovery outcomes, but abstinence-specific support is most critical to long-term recovery (Beattie & Longabaugh, 1999; Groh et al, 2007). The risk of relapse following recovery initiation rises in relation to the density of heavy drug users in one's post-treatment social network and declines in tandem with social network support for abstinence (Bond et al, 2003; Dennis et al, 2007; Mohr et al, 2001; Weisner, Matzger, & Kaskutas, 2003; Best et al, 2008). Social support is one of the primary mechanisms of change within recovery mutual aid societies and may be particularly effective in enhancing recovery for individuals embedded in heavy drug using social networks (Humphreys, Mankowski et al, 1999; Humphreys & Noke, 1997; Project MATCH Research Group, 1998; Bond, Kaskutas, & Weisner, 2003). The presence or absence of family and peer support for abstinence is a particularly powerful influence on the recovery outcomes of adolescents treated for a substance use disorder (Godley & Godley, in press).

Recovery Durability

3.35 The point of recovery stability/durability (at which the risk for future lifetime relapse drops below 15%) is typically between 4 and 5 years of sustained recovery for alcohol dependence, but potentially longer for other drug dependencies (e.g. opioid addiction, see White & Kurtz, 2006 for review). Little is known about the dynamics of relapse following a prolonged period of stable recovery (White & Schulstad, 2009). Recovery careers—their initiation and durability—are profoundly influenced by the interaction of problem severity/complexity and personal recovery capital. Recovery capital is the quantity and quality of internal and external resources that can be mobilised to initiate and sustain the resolution of severe alcohol and other drug problems (Granfield and Cloud, 1999). Internal assets can be thought of as personal recovery capital and external assets can be thought of in terms of family and community recovery capital (White & Cloud, 2008). Thus, recovery capital will change over time and is amenable to measurement as a mechanism for assessing appropriate interventions.

3.36 A person seeking recovery with moderate drug problem severity but high recovery capital might well achieve and sustain recovery on their own, through screening and brief professional intervention, or through support from an indigenous or non-specialised service resource, e.g. recovery support group. A person with high drug problem severity and complexity but exceptionally high recovery capital might be appropriate for outpatient detoxification and outpatient treatment despite a level of problem severity that, viewed in isolation, would justify inpatient care. In contrast, a person with low drug problem severity but high risk factors paired with extremely low recovery capital might be in need of residential treatment, ongoing professional support and prolonged peer-based recovery support (White and Cloud, 2008). Finally, a person with high problem severity and low recovery capital will likely require services of high intensity, broad scope (e.g. outreach, assertive case

[11] Excerpt from White (2009b)

management, and sustained recovery coaching), and long duration (White and Cloud, 2008). This is similar to the 'quadrant model' proposed for dual diagnosis by Mueser and Drake (2007) and adopted in *Mental Health in Scotland: Closing the Gaps - Making a Difference* (Scottish Government, 2007) and requires a sophisticated and flexible approach to assessing client functioning across multiple domains.

Family and Community Recovery

3.37 The family as a unit and individual family members can be harmed by the addiction of one or more family members. The need to repair the health of family members and family functioning as a whole can be conceptualised as a process of 'family recovery' (White, 2008a). Family recovery involves repair of family rules, roles and relationships across three family subsystems (adult intimate relationships, parent-child relationships, sibling relationships) and altering (increasing or decreasing) the family's interactions with the outside world. Family recovery from severe AOD problems is extremely stressful and potentially destabilising, spans years, and can be enhanced by professional and peer support (Brown & Lewis, 1999).

3.38 AOD problems are often transmitted intergenerationally within families. It is unclear the extent to which recovery in one generation influences resistance to or recovery from AOD problems in the next generation, although the evidence from Callan and Jackson presented below (1985) would provide some hope that parental recovery can act as a barrier to inter-generational transmission. Strategies to break these intergenerational cycles of problem transmission warrant experimentation and rigorous evaluation. The concept of recovery can also be applied to larger social systems to the extent that a community's ability to sustain its own health and survival has been compromised by injuries resulting from the magnitude of AOD problems. Therefore, in this context, one can also speak of the need for 'community recovery' (White, 2007).

3.39 One of the key challenges of a recovery model is to reconcile traditional outcome approaches, based largely on measuring pathology severity and remediation in treatment, with 'hard' indicators that reflect both individual growth and strength and that focus on the social and community aspects of recovery. These are likely to include measures of community engagement and activity; effective parenting and family engagement; and meaningful engagement in activities including, but not restricted to, employment. This includes the direct effects of parental support but also the indirect effects of better family integration that result from ongoing parental engagement in mutual aid groups (Andreas & O'Farrell, 2009). However, it is both the longevity of the recovery process and the expected individual variability in goals and their achievement that make this a challenging model for quantitative researchers to engage with. This issue is explored further in Chapter 6 and again in the concluding chapter (Chapter 8).

What Works in Relationship to Communities of Recovery and Related Recovery Support Institutions?[12]

Community Perspectives

3.40 There is growing recognition that recovery initiation in institutional settings does not assure sustained recovery maintenance in the community environments of home and work settings (Weisner, Matzger, & Kaskutas, 2003; Westermeyer, 1989). New recovery community support institutions are helping anchor recovery within these natural environments. Addiction recovery mutual aid societies are growing in size and achieving wide geographical dispersion and philosophical diversification (Humphreys, 2004; White, 2004). There are historically significant recovery community building activities underway, including the spread of recovery homes, recovery schools, recovery industries, recovery ministries/churches, and new recovery community organisations and service roles (Jason, Davis, Ferrari et al, 2001; Valentine, White, & Taylor, 2007; White & Finch, 2006; White, 2006b). However, in spite of anecdotal evidence of this in the UK, there has been little formal evaluation, with the Scottish Government funded evaluation of LEAP (The Lothians and Edinburgh Abstinence Programme) being one of the few examples. A new grassroots addiction recovery advocacy movement, exemplified on the Wired In[13] and Faces and Voices of Recovery[14] websites, is:

1) calling for a reconnection of addiction treatment to the larger and more enduring process of addiction recovery;
2) advocating a renewal of the relationship between addiction treatment institutions and grassroots recovery communities; and
3) extolling the power of community in the long-term recovery process (Elise, 1999; Morgan, 1995; White, 2002, 2009b). The growth of associations, community champions and recovery-oriented institutions in communities creates a social learning foundation for what can be the 'contagion' of recovery in local communities and increased visibility of recovery communities.

3.41 These efforts mark a growing focus on the 'ecology of addiction recovery' – how the relationships between individuals and their physical, social, and cultural environments promote or inhibit the long-term resolution of severe alcohol and other drug problems.

3.42 Early engagement with community supports and mutual aid is not straightforward and individuals will frequently need support and encouragement. Timko and colleagues (2006) assessed the effects of an intensive referral approach to 12-step facilitation programmes in a USA treatment setting, self-help groups arranged the recruitment of a volunteer to meet the patient and take them to a meeting. This was associated with significantly greater attendance than standard referral by advice or leaflet and resulted in greater engagement with 12-step at six-month outcome point as well as better drug and alcohol use outcomes at the follow-up. In other words, it is critical that bridges are built between professional and

[12] Excerpt/abstracted from White, 2009b
[13] http://wiredin.org.uk [accessed 5th March 2010]
[14] http://www.facesandvoicesofrecovery.org [accessed 5th March 2010]

community groups and that professionals make the time and effort to familiarise themselves with the community support groups available for their clients.

3.43 Families, kinship, social networks and communities can be considered in need of recovery when the health and performance of its members and the system as a whole have been severely impaired by alcohol or drug problems (White, 2007). In this view, parallel processes exist between the wounding and healing of the individual, the family and the community. Much of what is known about the recovery of individuals (De Leon, 1996; White, 1996) is paralleled in the recovery of families (Brown & Lewis, 1999), kinship and social networks (Galanter, Dermatis, Keller, & Trujillo, 2002), and whole communities (Williams & Laird, 1992).

3.44 Individuals with severe AOD problems can be viewed as victims of their own vulnerabilities or as symptoms of system dysfunction (i.e. by-products of a breakdown in the relationship between the individual, the family and the community). In historically oppressed communities, hope for individuals and families is best framed within a broader vision of hope for people, e.g. attaining social justice; addressing disparities in health, stigma, and discrimination; and widening doorways of community participation and contribution for all people (White, 2009a). There are three essential treatment-related strategies to enhance the healing power of the community in the long-term recovery process: outreach, in reach, and recovery community building (see community development section in Chapter 4).

1. **Outreach** is the extension of professional addiction treatment services into the life of the community, including supporting clients within their natural environments following the completion of primary treatment. Outreach strategies include community education efforts, early case identification and engagement via formal outreach, screening and brief intervention programmes, linking local harm reduction and recovery support resources, delivering services in non-traditional service sites, and enhancing the community visibility of people in long-term recovery.
2. **In-reach** is the inclusion of indigenous community resources within professionally directed addiction treatment. In-reach strategies include engaging each person's family and social network in the treatment process, establishing strong linkages between indigenous recovery support groups and addiction treatment institutions; and utilising consumer councils, alumni associations and volunteer programmes to saturate the treatment milieu with people representing diverse styles of long-term recovery. This might involve joint training between formal treatment providers and community and mutual aid groups; information sharing fora; joint assessments and case reviews and regular visits and exchanges. This is one mechanism for overcoming a 'silo' model where professional treatments exist in a separate and unconnected realm to the recovery activities in communities and in voluntary organisations. Thus, services that have introductory sessions from AA and NA groups and who include people in recovery in the brief and full assessment processes are examples of integration of community and treatment models, based on an in-reach approach.
3. **Recovery community building** encompasses activities that nurture the development of cultural institutions in which persons recovering from severe AOD problems can find relationships that are recovery-supportive, natural (reciprocal), accessible at times of greatest need (e.g. nights and weekends) and potentially

enduring. Recovery community building activities include cultivating local recovery community (advocacy) organisations and peer-based recovery support groups, promoting the development of local peer-based recovery support services/institutions focusing on such areas as recovery-focused housing, education, employment and leisure (White, 2009b).

Role of Recovery Mutual Aid Group Participation in Long-Term Recovery[15]

3.45 Scientific studies regarding the effects of participation in recovery mutual-aid societies on long-term recovery outcomes are limited in scope and methodological rigour, although the span and rigour have increased significantly in the past decade (Humphreys, 2006). Most of what is known about mutual-aid and recovery outcomes is based on studies of the effects of involvement in Alcoholics Anonymous of individuals following addiction treatment. Seen as a whole, these studies conclude that participation in recovery mutual-aid societies typically enhances long-term recovery rates, elevates global functioning, and reduces post-recovery costs to society among diverse demographic and clinical populations (Kelly & Yeterian, 2008; White, 2009a). Individual responses to recovery mutual-aid groups are variable, including those who respond optimally, those who respond partially, and those who fail to respond (Morgenstern et al, 1996). Recovery mutual aid participation has multiple active ingredients, including motivational enhancement for recovery, reconstruction of personal identity, reconstruction of family and social relationships, enhanced coping skills, and the personal effects of helping others. The effects of recovery mutual aid involvement are interdependent with the timing, frequency, intensity, and duration of involvement. For clients in addiction treatment, affiliation with and benefits from recovery mutual-aid societies are influenced by counsellor attitudes toward mutual aid, the style of linkage (assertive versus passive, degree of choice, and personal matching), and the timing of linkage (during treatment versus following treatment). The potential positive effects of recovery mutual-aid participation are often not achieved due to weak linkage procedures and high early dropout rates (See further discussion below).

3.46 There is also increasing evidence that post-treatment engagement in mutual aid has benefits to the children of substance-using parents. Andreas and O'Farrell (2009) reported on the impact of AA attendance after formal treatment on the psychiatric well-being of children of alcoholic fathers, as outlined above and discussed in chapter 6 and the conclusion. They found that fathers' greater involvement in AA groups predicted children's lower externalising problems. Similarly, Callan and Jackson (1985) assessed adolescent children of recovering alcoholics in Queensland, Australia and found that the children of fathers in long-term recovery from drinking rated their families as happier, more cohesive, more trusting and more affectionate than families where the fathers still drank. While this was not based on randomisation, the difference between groups would suggest that it was the influence of the 12-step engagement that predicted improvement in child functioning. Thus, there is an emerging evidence base to indicate the familial benefits of parental recovery, and mutual aid engagement, measured by both self-report and diagnostic indicators.

[15] Excerpted/abstracted from White, 2009a

What Works in terms of Recovery Management and Recovery-Oriented Systems of Care?

3.47 Brief episodes of crisis-induced abstinence, biopsychological stabilisation, and the resulting flush of health and great intentions do not constitute sustainable recovery and are as likely to be milestones in one's addiction career as a portal of entry into long-term recovery (Scott, Foss, & Dennis, 2005; Venner et al, 2005). Scientists, clinical leaders and recovery advocates are calling for a shift in the design of addiction treatment from a model of acute biopsychosocial stabilisation or palliative care to a model of sustained and assertive recovery management that would emulate the best treatment practices used to manage other chronic health conditions (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000; O'Brien & McLellan, 1996; White, Boyle, & Loveland, 2002; White & McLellan, 2008). Interest is also growing in public health and harm reduction strategies that integrate environmental and clinical strategies of AOD problem resolution (Kellogg, 2003; Tatarsky, 2003). Recovery is not an alternative to harm reduction.

3.48 The acute care (AC) model of specialised addiction treatment has measurable positive effects when compared to no intervention or alternative non-specialised interventions, but these effects vary widely by programme, counsellor, and population served. Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilised to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a local, state, or federal treatment agency but a macro level organisation of a community, a state, or a nation. The model that White (2008a) has outlined is based on the idea that 'strategic recovery champions' will work to shift not only the attitudes of individual professionals, and the practices in specialist services, but that overall treatment systems (such as the Alcohol and Drug Partnerships, ADPs, in Scotland) will be re-structured over time to be recovery-oriented in the sense that the ethos of the system will be around client empowerment and choice, and the distillation of hope for individual, family and community recovery.

3.49 Recovery management (RM) is a philosophical framework for organising addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilisation, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders (White, 2008a).

3.50 One particular version of the recovery-oriented system of care is the Recovery Oriented Integrated System (ROIS) developed by George de Leon (e.g. De Leon, 2007), based on 40 years of research work primarily focused on the therapeutic community (TC) setting. Therapeutic communities in the drugs field grew up in the USA in the 1960s and 1970s and were based on the idea that collective endeavour and group processes among those in recovery were inherently therapeutic and that the professional and specialist input was less important in this rehabilitative setting. Therapeutic communities, such as Phoenix House and Daytop, have become iconic models for therapeutic group processes and have been replicated across the world both in community and prison settings.

3.51 This has been widely used in the criminal justice system in the USA to facilitate re-entry of offenders into the community on their release. The model relies on a variety of services and endeavours, as well as group treatment providers working together and sharing ideas and a common language, to enable the individual to establish the main building blocks of recovery. However, the basic building block of the ROIS is the 'cadre' of individuals setting out on recovery journeys who will support each other and who will act in effect as a 'micro-TC' that will graduate through stages of recovery as a group and who will be the basic support unit for that cohort of clients. The TC model embeds the individual within a collective group entity to a much greater extent than the ROSC model which promotes a much greater personalisation model of recovery within a community environment, although there is limited empirical evidence that supports this model in a community context (De Leon, 2007).

3.52 The basic idea is that treatment and aftercare must be integrated to sustain the individual in the recovery process, and that for this to happen there must be a shared recovery approach among provider agencies in delivering coherent packages of support. This model has been piloted in the North-West of England (Gilman, 2008), based on the notion of the Drug Action Team as the strategic visionary and the lead for the overall model of integration at the level of service. This then creates the therapeutic space that allows cohorts of individuals in recovery to support each other on a recovery process that is much too long and intensive to be restricted to what is available through acute treatment services.

Measuring Effectiveness of Treatment Systems within a Recovery Model

3.53 Recovery-focused performance measures include three dimensions of systems evaluation:

1) measures of infrastructure stability and adaptive capacity;
2) recovery-focused service process measures; and
3) long-term recovery outcome measures[16].

3.54 Infrastructure stability and adaptive capacity reflect the capacity of an organisation to undergo systems transformation processes (e.g. from an Acute Care to a Recovery Management model of care) and the capacity of an organisation to fulfil its commitment for continuity of contact and support over time to individuals and families seeking long-term recovery. Recovery-oriented service process measures are intermediary outcomes (e.g. early identification, engagement and retention) that are linked to the final goal of long-term individual and family recovery. Long-term recovery outcome measures represent the major fruits of recovery, defined here as the resolution of alcohol and other drug problems; the progressive achievement of global (physical, emotional, relational) health; and positive community integration (elimination of threats to public safety; life meaning and purpose, self-development, social stability, and social contribution) (White, 2008a). The scope of recovery outcome measures include a focus on quality of life markers and effective

[16] The "Person in Recovery Self-Assessment" form developed as part of the "Tools for Transformation" series (Philadelphia Department of Behavioural Health and Mental Health Retardation Services, 2006) is one instance of a new measure that attempts to provide outcome indicators linked to long-term and sustained recovery.

engagement with families and communities on the one hand, and on the other greater prominence for meaningful activities such as working and volunteering and less of a focus on pathology. Thus, the recovery model does not presume the overall resolution of all symptoms, favouring instead a model based on strengths and opportunities rather than the final resolution of all illness symptoms.

Attraction and Access of Treatment

3.55 Only 10% of persons meeting criteria for a substance use disorder receive specialty sector addiction treatment in any year in the USA, and only 25% of persons meeting criteria for a substance use disorder will receive such specialised treatment in their lifetime (SAMHSA, 2003; Dawson, Grant, Stinson, et al, 2006). According to the UK Focal Point Report (Department of Health, 2008), there were 12,902 presentations to drug treatment in Scotland in 2006/07, compared to 104,062 in England, with Scotland having a slightly higher rate of opiate presentations as primary drug (67.0% compared to 64.1%) and a much lower rate of presentations for cocaine powder or crack (5.6% in Scotland and 14.1% in England). The same report also estimated the rate of problem drug use per 1,000 population as 9.97 in England and 15.39 in Scotland. Treatment seeking in Scotland (new presentations as a proportion of estimated PDU population) was lower at 25.0% than the 31.3% in England in 2006/07.

3.56 Multiple factors impede an individual's ability to seek help for AOD problems. These may include misperceptions of the severity of AOD problems; misjudgements regarding self-capabilities to resolve AOD problems, treatment-related social stigma, the lack of critical treatment supports such as transportation or day care, and resistance to complete abstinence as the only proffered treatment goal (Cunningham et al, 1993; Ellingstad et al, 2004; Grant, 1997; Tucker et al, 2004; Wechsberg et al, 2007). The Acute Care model attracts only a small percentage of persons admitted to addiction treatment, with most persons entering treatment under external coercion at a late stage of problem development (Institute of Medicine, 1990; Wild, 2006). This does not imply that coerced treatment is ineffective compared to voluntary treatment, but the status of mandated treatment for the bulk of those entering treatment signals that treatment services are reaching people primarily at later stages of their addiction careers when prognoses for long-term recovery have been compromised. Efforts need to be made to reach people at far earlier stages of problem development when recovery capital is still available to enhance long-term outcomes, and this is likely to result from both the in-reach and outreach models (outlined above).

3.57 High pre-treatment drop-out rates (initial contact without service initiation—ranging from 25% to 50%) are linked to personal ambivalence, lack of geographical or financial access, waiting lists, and personal obstacles to participation, based on research that assessed failures to engage in community treatment in the USA (Gottheil et al, 1997). Promising practices to increase early engagement include social marketing of AOD problem resolution options and successes, assertive models of outreach, lowered thresholds of engagement, interim services for those on waiting lists, short-term case management to enhance engagement, regular check-ups for those resisting immediate service entry, telephone prompts through the early engagement process, family mobilisation strategies, extended clinical hours, and

delivery of services in non-stigmatised sites (White, 2008a). Thus, the recovery management check-up model described below uses peers to engage with those completing treatment to encourage and motivate and to enhance re-engagement rates in the event of early relapse (Dennis et al, 2009).

Screening, Assessment, and Level of Care Placement

3.58 Early screening and brief interventions for AOD problems are effective strategies for reaching persons with AOD problems who are involved in non-specialised community-based service settings, particularly primary health care settings (National Institute of Alcohol Abuse and Alcoholism [NIAAA], 2002). RM models of assessment differ from the AC models in key dimensions: assessment processes are not just about pathologies, and focus on the broader context of family life and life in the community, and crucially are about building on strengths rather than simply listing and attempting to resolve pathologies. Assessment and recovery planning are also seen as ongoing and real-time, with the aim of monitoring and supporting current needs. Where level of care decisions in the AC model focus primarily on problem severity and complexity, such decisions in the RM model are heavily influenced by the assessment of personal, family, and community recovery capital (White et al, 2002), and attempt to promote strengths as the building blocks of recovery.

3.59 Promising practices related to screening, assessment, and placement include AOD problem screening in primary care settings, Internet-based screening services, use of standardised global assessment instruments, family-focused assessment protocol, and regular recovery community resource mapping (White, 2008a).

Service Team Composition

3.60 Recovery Management models of addiction treatment increase the involvement of medical, psychiatric, and other allied professionals (such as social work and primary care professionals) and of peer-based recovery support specialists. Recovery Management models of care also emphasise multi-agency models of intervention and embrace a larger goal of breaking intergenerational cycles of problem addiction transmission, thus providing a framework for the integration of primary prevention, early intervention, treatment and long-term recovery support strategies.

3.61 In the UK mental health field, there has been the recent development of Assertive Community Teams (ACTs) that are predicated on the idea that recovery-oriented treatment must have an increasingly community focus (e.g. Phillips et al, 2001). This is based on the evidence that this type of programme is effective in reducing hospitalisation, is no more expensive than traditional care, and is more satisfactory to consumers and their families than standard care.

3.62 Promising practices that enhance service team composition include providing primary medical/psychiatric care in tandem with addiction treatment, the use of recovery coaches to provide continuity across levels of care, increased use of volunteers, and the creation of multi-agency, multi-disciplinary service teams (White, 2008a).

Service Relationship/Engagement

3.63 Pre-treatment dropout rates in addiction treatment exceed 50% of those who initially call regarding services (Gottheil et al, 1997). Less than half the people admitted to addiction treatment services in the USA successfully complete treatment (SAMHSA, 2002), although the retention rates reported in the NTA's Annual Report for 2009 indicate markedly higher retention rates in England, where 92% of people engaged in treatment were successfully retained in treatment for 12 weeks or more (NTA, 2009; NTA, 2010). For people who do not complete addiction treatment, both those who drop out and those who are extruded via administrative discharge constitute those who are in greatest need of such treatment (Stark, 1992; Samantaray et al, 1997).

3.64 In the UK, there is an additional problem which relates to the low intensity of treatment delivery. Best and colleagues (2009) have shown that in statutory treatment services in the UK, many clients are seen infrequently (often fortnightly) and for short periods of time (typically for around 45 minutes per session), and that the delivery of evidence-based psychosocial interventions is minimal in terms of the delivery of structured interventions such as cognitive-behavioural or motivational interventions (for a wider discussion of psychosocial interventions see chapter 4). Thus, the question of whether treatment is effective is often replaced by a conundrum of why clients receive so little of it with the consequent implications for the delivery of recovery-oriented interventions. The problem identified in this study of mainly UK NHS services was not only that was there sub-optimal delivery of therapeutic interventions; there was also little evidence that clients were being offered real recovery options within the treatment service.

3.65 The service relationship in the Recovery Management model shifts from that of a professional expert 'treating' a 'patient' to that of a consultant providing sustained support to individuals and families as they progress through multiple stages of long-term recovery. Recovery management emphasises use of a 'choice philosophy' (importance of clients setting their own treatment goals and formulating their own recovery action plans; Borkman, 1998; White, 2008b; SAMHSA, 2005a).

3.66 Promising practices in enhancing engagement and retention include the use of motivational interviewing, using more senior staff to induct new enrolees into treatment, participation incentives, altering administrative discharge policies and practices, using a choice philosophy to expand the range of client decision-making, increasing the focus on therapeutic alliance in training and supervision, and monitoring engagement indicators for each service unit and for counsellor (White, 2008a). Although this is a more resource intensive approach, it is associated with earlier client engagement in the treatment process which in turn is linked to better retention and improved outcomes (Simpson, 2004).

Service Dose, Scope and Quality

3.67 Length of service contact is the best single predictor of post-treatment addiction recovery status (Hubbard et al, 1989; Hubbard et al, 2002; Simpson et al, 1999; Simpson, 1997), a finding that was repeated in the NTORS project in England (Gossop et al, 2003). In the USA, length of time in treatment has decreased through

the modern evolution of addiction treatment, with the majority of clients discharged from addiction treatment receiving less than the minimum 90 days of service contact recommended by the National Institute on Drug Abuse. Expanding the scope of ancillary medical, psychiatric, and recovery support services in addiction treatment can elevate long-term recovery outcomes, but such service comprehensiveness is not the norm within the addiction treatment service sector (McLellan et al, 1994; McLellan, Hagan, Levine, et al, 1998). Progress is being made integrating evidence-based practices (such as the use of manualised psychological interventions) within mainstream addiction treatment, but treatment methods continue that are ineffective or potentially harmful (McLellan et al, 2003; White & Kleber, 2008).

3.68 Promising practices related to the dose, scope, and quality of addiction treatment services include greater use of stepped care, more assertive linkage to recovery support groups and post-treatment recovery support institutions (e.g. recovery homes, recovery schools, and recovery ministries), co-location of medical/psychiatric/social services, increased emphasis on evidence-based treatments, increased monitoring of fidelity to preferred service methods via clinical supervision, and increased communication between clinicians and researchers (White, 2008a).

Assertive Linkage from Treatment to Communities of Recovery

3.69 Participation in recovery mutual aid groups can elevate long-term recovery outcomes for diverse populations (White, 2009a). The effects of recovery mutual aid involvement reflect multiple mechanisms of change and vary by the number of meetings in early recovery, duration of participation, and intensity of participation (See Kaskutas, in press, and Kelly & Yeterian, 2008 for recent reviews). Combining addiction treatment and recovery mutual aid for persons with severe substance use disorders is more effective than when either is used alone (Fiorentine & Hillhouse, 2000).

3.70 The positive effects of recovery mutual aid groups are compromised by weak linkage and progressive attrition in participation over time. Half of all USA clients completing treatment do not participate in recovery support groups after discharge, and of those who do, 40% to 60% discontinue participation within a year of treatment discharge (Tonigan et al, 2002; Tonigan et al, 2003; Kelly & Moos, 2003; Donovan & Wells, 2007). Assertive linkage to a recovery support group is more effective than passive referral (verbal encouragement to attend), but the linkage process in most treatment programmes is of the passive variety (Forman, 2002; Timko et al, 2006). Participation in other recovery community institutions (e.g. recovery homes, recovery schools, recovery industries, recovery support centres, recovery ministries/churches) may enhance long-term recovery, but evaluation of this potential is at an early stage (For review, see White, 2009).

3.71 Promising practices related to linkage to communities of recovery include enhanced institutional linkages between treatment institutions and communities of recovery, use of assertive linkage procedures, orientation and linkage to Internet-based recovery support groups, and expanding treatment philosophies to embrace diverse religious, spiritual, and secular pathways of recovery (White, 2008a).

Post-Treatment Monitoring, Support and Early Re-Intervention

3.72 Post-treatment monitoring and support can significantly elevate long-term recovery outcomes, but only a small percentage (20% to 36%) of adolescents and adults completing addiction treatment receive post-treatment continuing care in the USA (Dennis et al, 2003; Godley et al, 2001; McKay, 2005; Scott et al, 2005). Recovery Management models of continuing care are distinguished from Acute Care models by several critical factors: Post-treatment monitoring and support is provided to all clients, not just those discharged; responsibility for continued contact is with the service staff rather than the client; saturated support is provided in the first 90 days following discharge from treatment; and 'recovery check-ups' are provided for an extended period of time (up to five years). The timing and duration of post-treatment support exert a greater influence on long-term recovery outcomes than the total number of support contacts or the length of each support contact (Ritsher et al, 2002). The telephone and the Internet constitute two underutilised media for post-treatment monitoring, support and early re-intervention.

3.73 Promising practices related to post-treatment monitoring and support include enhancements aimed at participation (behavioural contracts, prompts, financial incentives), removing barriers to participation, extending time-span of support via recovery check-ups, telephone- and Internet-based systems of continuing care, and expanding the range of environments in which continuing care occurs, e.g. home- and work-based follow-up (White, 2008a).

Treatment/Recovery Outcomes

3.74 As discussed, reported treatment outcomes vary by definitions of key measures, e.g. abstinence, sobriety, recovery, lapse, relapse, success. Post-treatment evaluations consistently report improved odds of sustained abstinence, reduced AOD consumption by those who use, a reduction in AOD-related problems, and reductions in crime and risk of HIV infection (See White, 2008 for review). The majority of people completing specialised addiction treatment resume some AOD use in the year following treatment (Anglin et al, 1997; Institute of Medicine, 1998). Findings from large-scale outcome studies in the USA show that post-treatment relapse rates are higher for men, adolescents, persons dependent on opiates, and persons with co-occurring substance use and psychiatric disorders. Between one-quarter and one-third of all clients discharged from addiction treatment will be re-admitted to treatment within one year, and 50% will be re-admitted within two to five years (Grella et al, 2003; Simpson et al, 2002; Simpson et al, 1999). The majority of persons entering addiction treatment already have one or more prior admissions (SAMHSA, 2005b). Clients discharged from addiction treatment have high post-treatment mortality rates—1.6 to 4.7 times greater than age-matched populations without substance use disorders (See White 2008 for a review). Stable recovery can be preceded by years of cycling in and out of sobriety experiments (Scott et al, 2005). Such findings underscore the need for post-treatment monitoring, sustained support, and, when needed, early re-intervention.

The Evidence Base for Recovery in the UK

3.75 The primary source of recovery evidence in the UK, at least from a drugs' perspective, comes from 70 semi-structured interviews conducted by McIntosh and McKeganey and published in papers in 2000 and 2001. The participants were recruited through snowball sampling, advert and from follow-up contact with former users of treatment services, and covered a wide range of routes to recovery and extent of recovery duration. Unusually, 52% of the sample was female (compared to the 25-33% typically reported in prevalence and treatment studies). Among the key desistance factors identified were developing new activities and relationships and developing a commitment towards new and changed lifestyles, at least in part by developing an identity as a non-addict. The authors identified two main mechanisms by which former users avoided relapse:

> *'(1) the avoidance of their former drug-using network and friends and (2) the development of a set of non-drug-related activities and relationships' (McIntosh and McKeganey, 2000).*

3.76 In *Beating the Dragon*, McIntosh and McKeganey (2001) also reported on the key role of meaningful activities in providing a distraction from drugs; in establishing a new and more positive sense of self and in providing new relationships that were able to support that new sense of identity. They also comment on the relatively minor role of treatment in recovery stories:

> *'it was notable how little time our interviewees spent talking about the contribution of drug-misusing services when describing their recovery' (McIntosh and McKeganey, 2001, p131)*

3.77 Instead, interviewees focused much more on the transition in their own personal identities and their family functioning.

3.78 In 2008, Best and colleagues published the findings of a survey of 107 former problematic heroin users who have achieved long-term abstinence about their experiences of achieving and sustaining abstinence. The cohort was recruited opportunistically from three sources, drawing heavily on former users working in the addictions field. On average, the group had heroin careers lasting for just under 10 years, punctuated by an average of 2.6 treatment episodes and 3.1 periods of abstinence - the most commonly expressed reason for finally achieving abstinence was 'tired of the lifestyle' followed by reasons relating to psychological health. In contrast, when asked to explain how abstinence was sustained, clients quoted both social network factors (moving away from drug using friends and support from non-using friends) and practical factors (accommodation and employment) as well as religious or spiritual factors.

3.79 Overall, while there is a considerable volume of research published around recovery, the majority of this work has been carried out in the USA and much of it involves alcohol. In the UK, much of the evidence base around recovery is based on mental health and there is limited evidence available on the typical recovery careers of heroin users in the UK or of the factors that are associated with desistance. Even less is known about the careers of primary stimulant users or those of polydrug users

or about the impact of either co-morbid mental health problems or primary recidivism on the careers of illicit drug users and their subsequent transitions to long-term recovery.

3.80 The story of recovery remains an incomplete one with the need for considerable translation and interpretation to apply the existing evidence to a drug context in Scotland. Nonetheless, there are grounds for assuming some generalisable principles from the diversity of recovery evidence presented above and from the general principles of recovery – the need for a systems transformation in services to a philosophy based on empowerment and hope; to the recognition that recovery is a long-term goal that will take place in communities and not in specialist treatment settings (typically over a 5-7 year period for heroin users); that the pathways will vary across individuals and substances, according to severity and complexity, but that the predictors of sustained recovery will be strengths and not pathologies; and that the presence of local recovery champions and groups will make a difference to the recovery experience.

CHAPTER 4: TREATMENT OF DRUG DEPENDENCE AND EVIDENCE OF EFFECTIVENESS

Summary: Key Findings from the Effectiveness and Outcomes Literature

1. International studies consistently show that treatment leads to improved outcomes across a range of treatment modalities including community and residential treatment and both abstinence and maintenance oriented interventions.
2. This is true across a range of treatment modalities, which demonstrate value for money for treatment delivery, with the most recent UK study, DTORS, suggesting a cost effectiveness ratio of 2.5:1 for savings in health and social care compared to treatment costs.
3. Retention in treatment for 90 days has been shown to be the threshold for 'treatment gain' in community settings.
4. There is a strong evidence base supporting methadone substitution treatment in maintenance settings, but this requires not only prescribing but also adequate psychosocial support and links to 'wraparound' care.
5. Scottish outcome research has shown that while methadone maintenance leads to improved outcomes in a range of domains, it is associated with low rates of sustained abstinence.
6. Continuity of care is a critical component of effective treatment systems, and there is a strong supportive evidence base around linkage to 12-step and other community 'aftercare' supports.
7. There is an ongoing challenge for the delivery of psychosocial interventions – while there is a strong evidence-base from trials, there is little evidence that these are routinely translated into everyday clinical practice.
8. 'Technology transfer' research of the kind undertaken in the Treatment Effectiveness Initiative in England is essential to improve the quality of treatment for staff and clients.

4.1 It is now clear that drug misuse treatments can be effective in reducing drug use and other problem behaviours. Studies conducted over the past three decades have compared treatment with no treatment (or minimal treatment), and post-treatment with pre-treatment problem behaviours. Studies showing the effectiveness of drug misuse treatments have been conducted with clients with different types of drug problems, with different treatment interventions, and in different treatment settings.

4.2 In a comprehensive and detailed review, McLellan (1997) concluded that specialist drug misuse treatment in both community and residential settings is effective in terms of reduced substance use, improvements in personal health and social functioning, and reduced public health and safety risks. Similarly, in a meta-analysis of 78 studies of outcomes among clients who received either minimal treatment or no treatment, Prendergast et al (2002) found that the effects of treatment for drug use and crime outcomes were positive, significant, and clinically meaningful. The authors concluded that drug misuse treatment has been shown to be effective in reducing drug use and crime, and that it may be more appropriate to stop asking whether treatment for drug abuse is effective, and instead to ask how

treatment can be improved, and how it can be tailored to the needs of different clients.

4.3 Treatment interventions should be appropriately responsive to the diverse needs of drug users who present to treatment with complex mixtures of substance use and other problems. The nature, severity and complexity of their problems may be expected to affect the ways in which treatment is provided. However, surprisingly little is known about the processes of treatment delivery, or how to identify 'active' and 'inert' components of treatment processes.

4.4 No single treatment is likely to be universally effective for drug dependence. A range of different interventions are required. Despite widespread recognition of the importance of providing treatments that are appropriate to the diverse needs of clients, many programmes offer only a single type of treatment. In such situations, those patients who are a good fit for a given approach are more likely to remain in treatment, and those who are less well suited are more likely to drop out (Carroll, 1997).

4.5 The idea of matching patients to treatment is widely accepted, but it is unclear precisely how this should be done in clinical practice. Existing treatment services seldom routinely conduct comprehensive assessments for large numbers of treatment seekers, who are then selectively referred to a diverse and well-developed system of treatment services. A more modest expectation is that interventions within each programme should be tailored to patient needs. But even this limited application of patient-treatment matching requires a level of sophistication in assessment procedures and availability of comprehensive services that is uncommon in the real world.

Pharmacologically Assisted Treatments

Detoxification

4.6 Detoxification procedures are used to alleviate the acute symptoms of withdrawal from dependent drug use (Department of Health and the devolved administrations, 2007). Detoxification is a preliminary phase of treatments aimed at abstinence and represents an intermediate treatment goal. Detoxification is not, in itself, a treatment for drug dependence, and, on its own, it is not effective in producing long-term abstinence. Drug users who received detoxification-only treatment derived no more therapeutic benefit than formal intake-only procedures (i.e. with no specific treatment).

4.7 The criteria by which the effectiveness of detoxification should be judged are: *acceptability* (is the user willing to seek and undergo the intervention), *availability, symptom severity, duration* of withdrawal symptoms, *side-effects* (the treatment should have no side-effects or only side-effects that are less severe than the untreated withdrawal symptoms), and *completion* rates.

4.8 Giving gradually reducing doses of oral methadone is one of the most commonly used procedures for the management of withdrawal from opiates. In a residential setting, detoxification is often managed over periods of 10-28 days. The

most widely used (and cheapest) option is outpatient/community detoxification. However, low completion rates are typically reported for opiate dependent patients detoxified in out-patient programmes. When detoxified on an outpatient basis, as few as 17-28% of those dependent on opiates achieve abstinence from opiates for even as little as 24 hours after treatment (Gossop et al, 1986; Dawe et al, 1991). This compares with completion rates for inpatient detoxification of between 80%-85%, using a standard 10-14 day detoxification window (Gossop et al, 1986; Gossop and Strang, 1991).

4.9 Medications such as clonidine and lofexidine have also been used in detoxification treatments. Clonidine and methadone produce broadly similar reductions in withdrawal symptoms, though patients experience more withdrawal symptoms in the first few days of clonidine treatment. Lofexidine has comparable clinical efficacy to clonidine, but fewer side effects, particularly postural hypotension (Buntwal et al, 2000). Lofexidine and clonidine could both be used successfully for out-patient detoxification, but treatment with clonidine requires more input in terms of staff time (Carnwath and Hardman, 1998). Detoxification with lofexidine can be achieved over periods as short as 5 days (Bearn et al, 1998). Encouraging results regarding the effectiveness of lofexidine are now available from a number of studies (Bearn et al, 1998; Buntwal et al, 2000), and within the past decade, lofexidine has been increasingly widely used in detoxification programmes across Scotland and the rest of the UK.

Maintenance Treatments

4.10 Methadone maintenance is the most thoroughly evaluated form of treatment for drug dependence. Methadone maintenance has higher treatment retention rates for opiate-dependent populations than do other treatment modalities for similar clients. Although methadone dosages need to be clinically monitored and individually optimised, clients have better outcomes when stabilised on higher rather than lower doses (Institute of Medicine, 1990; Department of Health and devolved administrations, 2007). In a meta-analysis of methadone maintenance studies, results showed consistent, statistically significant associations between methadone maintenance treatments and reductions in illicit opiate use, HIV risk behaviours and drug and property crimes (Marsch, 1998). For methadone maintenance treatment to be optimal, it has to be delivered as part of a package that includes both psychosocial interventions and 'wraparound' care such as support with housing, employment and training, debt management and physical and psychological health support.

4.11 In a Scottish context, Hutchinson et al (2000) reported on a one-year follow-up of GP-centred oral methadone and found that daily opiate injecting dropped from 78% to 2% and mean monthly number of acquisitive crimes dropped from 13 to 3, although only 29% remained continuously on methadone throughout the course of the study. The research was conducted in Glasgow, based on an analysis of new entrants into a methadone treatment programme, most of whom were not involved in treatment prior to the engagement with the index treatment.

4.12 In practice, methadone treatments are extremely diverse. Programmes differ in their structures, procedures and practices, in terms of the numbers of patients

treated, type and qualifications of staff, the amount and type of counselling and medical services provided, methadone doses, policies about urine testing, take-home methadone, and many other aspects of treatment (Stewart et al, 2000b).

4.13 Buprenorphine is increasingly used as a maintenance medication (Ling et al, 1998). It has been found to be of comparable effectiveness to methadone as a maintenance agent in terms of reducing illicit opioid use and retaining patients in treatment in a USA treatment context (Johnson et al, 2000). Buprenorphine is safer than methadone in terms of the risk of overdose since it produces relatively limited respiratory depression, and is well tolerated by non-dependent users.

4.14 In Scotland, Robertson et al (2006) conducted an open-label randomised trial comparing dihydrocodeine (DHC) and methadone in specialist treatment and GP settings in Edinburgh. Two hundred and thirty-five patients were randomised and, although there was greater attrition from the DHC group, no differences were reported in either the primary outcome measure, retention in treatment, nor in the secondary outcome measures of illicit opiate use, crime, physical and mental health, injecting, overdose, or engagement in education or work.

Psychosocial Treatments

4.15 Other treatments that are currently widely used to treat drug dependence are variously referred to as cognitive behavioural treatments or psychosocial treatments. These treatments have been developed based on the assumptions, theories and research traditions of psychology, and especially of social-learning theory.

4.16 *Relapse Prevention* combines behavioural skills training, cognitive interventions, and lifestyle change procedures (Marlatt and Gordon, 1985). Its primary goal is to teach drug users who are trying to change their drug taking behaviour how to identify, anticipate, and cope with the pressures and problems that may lead towards a relapse (Marlatt, 1985).

4.17 When 3-month and 6-month residential relapse prevention programmes were compared in a randomised trial, both were found to lead to significantly improved outcomes at follow-up, with results also suggesting that continued treatment beyond 3 months appeared to be beneficial in terms of delaying time to first drug using relapse (McCusker et al, 1995). A review of controlled clinical trials concluded that, for a range of different substances of abuse, there is evidence for the effectiveness of relapse prevention over no-treatment control conditions: relapse prevention was found to be of comparable effectiveness but not superior to other active treatments (Carroll, 1996).

4.18 Primary cocaine users with depression showed better treatment retention and reduced ongoing cocaine use when treated with relapse prevention compared to clinical management. Although all groups sustained gains they made in treatment, significant continuing improvement across time in patterns of cocaine use was seen for patients who had received relapse prevention compared with clinical management (Carroll et al, 1994).

4.19 *Motivational Interviewing (MI)* is now widely used to treat drug misuse. Motivational Interviewing is seen primarily as a counselling *style* rather than a treatment procedure. It can be useful in many stages of treatment but particularly in helping people who are still at the early stages of change. It has been found to be more beneficial for patients with lower initial motivation for treatment than for patients with higher initial motivation (Rohsenow et al, 2004). A systematic review of randomised trials of MI interventions found significantly improved outcomes in the majority of studies (Dunn et al, 2001). A meta-analysis of controlled trials also found that interventions using adaptations of motivational interviewing were superior to no-treatment and placebo comparison groups in terms of reduced substance misuse problems, but not for reductions in HIV risk behaviours (Burke et al, 2003).

4.20 *Contingency Management* provides a system of incentives and disincentives which are designed to make continued drug use less attractive and abstinence more attractive, with consequences made contingent upon behaviour. Contingency management techniques can be effective in reducing continued drug misuse among methadone patients (Strain et al, 1999), including their use of cocaine, and benzodiazepines. Many contingency management interventions have been conducted with patients in methadone treatment programmes since methadone dose, dose frequency, or the take-home option, lend themselves readily for use as reinforcers. Incentives have been found to be effective in leading to increased attendance at counselling sessions.

4.21 *Twelve step treatments, residential rehabilitation, and Therapeutic Communities* differ in several respects, but also share many common features. All owe their origins, to a greater or lesser extent, to the influence of Alcoholics Anonymous (AA), and they all share a common focus on abstinence as the overriding goal of treatment. These treatments see recovery from addiction as requiring a profound structuring of thinking, personality, and lifestyle, and involving more than just giving up drug taking behaviour.

4.22 An influential recent development has been the growth of relatively short-term, residential 'Twelve-Step Facilitation', 'chemical dependency' or 'Minnesota Model' programmes. These are generally closely linked to Twelve Step principles of AA/NA, and they typically provide a highly structured three to six week package of residential care involving an intensive programme of daily lectures and group meetings designed to implement a recovery plan based upon the Twelve Steps. This will typically involve an initial therapeutic rehabilitation phase, in which clients will work with therapists individually and in groups to analyse their true personality and their patterns of behaviour. Much of the focus of this initial phase will be around dealing with the issues that led the individual into active addiction which will be a challenging process for which a supportive therapeutic milieu is essential. This will then gradually switch to a focus on 'starting on the path to a new life' which will be about having a clear therapeutic philosophy and approach but embedded within developing the key skills needed for a new life.

4.23 Benefits of 12-step affiliation have been reported among drug misusers accessing community based treatment. A major study of drug use outcomes among cocaine-dependent patients studied 12-step group attendance and active 12-step participation accessing community based treatment (Weiss et al, 2005).

Participation in 12-step groups was predictive of reduced drug use among cocaine-dependent patients. Active 12-step participation by cocaine-dependent patients was found to be more important than meeting attendance, and the combination of drug counselling plus increasing 12-step participation was associated with the best drug outcomes. Consistent with other 12-step studies, it suggests that attendance and active engagement with 12-step is associated with marked improvements in substance use. NA/AA has also been found to be effective as a complementary intervention, and drug misusers frequently use both Twelve-Step and other types of drug treatment programmes as integrated services rather than as competing alternatives (Fiorentine and Hillhouse, 2000). Some studies have found favourable outcomes for those who attend NA/AA following other types of treatment (Ouimette et al, 1998).

4.24 The importance of post-treatment aftercare is widely accepted. The period immediately after leaving treatment is one of high risk of relapse, and adequate support should be provided for the patient during this period. However, only a minority of programmes have sufficient resources to provide any form of aftercare. Treatment programmes can use NA/AA as an aftercare resource merely by encouraging their clients to attend meetings. Ouimette et al (1998) found that patients who received no aftercare had the poorest outcomes: patients who participated in outpatient treatment plus twelve-step groups achieved the best outcomes at follow-up, in terms of reduced drinking days and days to relapse. Post-treatment NA involvement has been associated with better outcomes for drug patients in a number of studies.

4.25 Residential rehabilitation programmes are one of the longest established forms of treatment for drug addiction. Studies from the UK and the USA have shown improved outcomes after treatment in residential rehabilitation programmes. In DATOS, drug use outcomes after one year were good for clients who were treated in long-term residential and short-term inpatient treatment modalities in the USA. Regular cocaine use (the most common presenting problem for residential rehabilitation in the USA, but not in the UK where primary opiate use still predominates) was reduced to about one-third of intake levels among clients from both the long-term and short-term residential programmes, as was regular use of heroin (Hubbard et al, 1997). Rates of abstinence from illicit drugs have also been found to improve after residential treatment. In the UK, NTORS (see below) found that 51% of the drug misusers from residential rehabilitation programmes had been abstinent from heroin and other opiates throughout the three months prior to 2-year follow-up: rates of drug injection were also halved, and rates of needle sharing were reduced to less than a third of intake levels (Gossop et al, 2001). There was also good evidence that those who were abstinent at two years had generally sustained that over the period since the index treatment, suggesting that even short-term residential detoxification can be associated with significant positive change in substance use.

4.26 Casemix issues are relevant to the evaluation of residential programmes because such programmes often accept the most chronic and severely problematic cases. It is an explicit intention of stepped care treatment approaches that residential services should be used for the more difficult cases.

Longitudinal Treatment Outcome Studies

4.27 Large-scale, prospective, multi-site treatment outcome studies have played an important role in improving our understanding of treatment effectiveness. They provide valuable information about drug misusers, the stages of their addiction careers, their various and complicated involvements with treatment services, and the changes that occur in their drug use and other problem behaviours across extended periods of time after treatment. Such studies are rare, however, because of the high costs in money, effort, and organisational commitment necessary to implement, coordinate and sustain such data collection systems over many years.

4.28 One of the earliest follow-up studies was the investigation of 100 New York City male substance users admitted to Lexington Hospital in 1952 and 1953 (Vaillant, 1966, 1973). The majority of the sample was found to have relapsed after leaving Lexington, but drug use trends over time were toward reduced opiate use. Vaillant found 22% were abstinent after 5 years, and 37% after 10 years.

4.29 More recently, a number of major studies have been conducted. Table 4.1 summarises the key sources of treatment outcome studies conducted since this initial assessment and findings from each of these studies are summarised below.

The Drug Abuse Reporting Programme (DARP)

4.30 DARP was conceived in 1968 to monitor and evaluate the emerging USA federal addiction treatment system. DARP collected admission records for 44,000 patients at entry to 52 treatment agencies. Data were collected through intake interviews, during-treatment progress reports, and a series of follow-up interviews from 3 to 12 years after treatment. Over 6,000 patients were selected to participate in the first wave of post-treatment follow-up interviews which were conducted, on average, 6 years after admission. A second wave of follow-ups was conducted with a sample of 697 addicts, approximately 12 years after admission, with a follow-up rate of 70% (Simpson and Sells, 1990). DARP investigated four treatment types as well as a comparison group which enrolled but never started treatment. The four treatments were methadone maintenance, residential therapeutic communities, outpatient drug free (services that rely on counselling with an emphasis on abstinence), and outpatient detoxification. Reductions were found in the use of opiates and other drugs after treatment across all of the treatment modalities. Among those patients who had been daily users of opioids before treatment, more than half (53%) reported no daily opioid use at one year. Opioid use continued to decline over time until year 6, when it stabilised at 40% for 'any' use and 25% for 'daily' use. At some point during the 12 years following treatment, three-quarters of the sample had relapsed to daily opioid use, but at the year 12 interview, nearly two thirds (63%) had not used opioids on a daily basis for a period of at least 3 years.

4.31 Time in treatment was observed to be an important determinant of outcomes with a minimum of 3 months in treatment being linked to positive changes in drug use behaviour. Post-treatment outcomes became more favourable as time spent in treatment increased. No long-term effect was found for 21-day detoxification. For methadone maintenance, drug-free outpatient treatment, and the therapeutic communities, significantly higher percentages of patients who stayed in treatment for

Table 4.1 International treatment outcome studies included in the review

Name	Country	Dates	Sample	Treatment populations
Drug Abuse Reporting Programme (DARP)	USA	1968-1980 (12 year follow-ups)	44,000 at intake; over 6,000 followed up; 697 at 12 years	Methadone maintenance, therapeutic community, out-patient drug free, out-patient detoxification
Treatment Outcome Prospective Study (TOPS)	USA	1979 – 1986 (2 waves with 3-5 year follow-up)	11,750 patients at enrolment	Methadone maintenance, residential treatment and out-patient drug-free treatment
Drug Abuse Treatment Outcome Study (DATOS)	USA	1989 – 1991 (measures at 1 and 3 months in treatment and 12 months after)	10,010 at intake – 4,500 followed up at 12 months	Long-term residential; short-term inpatient; methadone maintenance and out-patient drug free
California Civil Addict Programme (CCAP)	USA	Intake waves in 1962 and 1964 and follow-ups to 24 years	581	Heroin addicts enrolled in the civil addict programme
National Treatment Outcome Research Study (NTORS)	England	Initiated in 1995 with one year, two year and five year outcomes	1,075 at intake from 54 programmes; 769 at one-year follow-up	Methadone maintenance and community detox; in-patient detox and residential rehabilitation
Drug Treatment Outcome Research Study (DTORS)	England	2006-2007, using a 12-month window;	1,796 baseline interviews; 886 interviewed at 3-5 months and 504 at 12 months	342 structured community or residential drug treatment services
Australian Treatment Outcome Study (ATOS)	Australia	Baseline, 3 and 12 month follow-ups; 2 and 3 year outcomes in one site (Sydney)	745 treatment sample and 80 non-treatment heroin controls	Methadone or buprenorphine maintenance; detoxification and residential rehabilitation; small non-treatment control group
Research Outcome Study in Ireland (ROSIE)	Ireland	Started in 2003 with a 6-month, 1-year and 3-year follow-up window	404 active treatment group with a sub-sample of 26 needle exchange users	Methadone maintenance / detoxification; structured detoxification; abstinence treatment
Drug Outcome Research in Scotland (DORIS)	Scotland	Initiated in 2001 with 8, 16 and 33 month follow-ups	1,007 individuals recruited from 28 specialist treatment agencies (community and residential) and five prisons delivering drug treatment	Substitute prescribing; non-substitute prescribing; counselling; residential rehabilitation and prison

longer than 90 days had favourable outcomes. For methadone, those staying longer had better outcomes (Simpson, 1981).

The Treatment Outcome Prospective Study (TOPS)

4.32 TOPS also provided longitudinal data on patients entering USA federally-funded drug abuse treatment programmes. The first intake data were collected in 1979. TOPS enrolled a total of 11,750 patients entering treatment in 41 addiction treatment programmes in 10 USA cities between 1979 and 1981. The treatment modalities studied were residential programmes, methadone maintenance, and out-patient drug-free programmes. Patients were interviewed on admission into treatment, and at 1 month, 3 months, 6 months, 9 months and 1 year after admission. For the follow-up interviews, a sample was followed up at 3 months, 1 year, 2 years and then 3-5 years after treatment.

4.33 TOPS showed that treatment was effective in reducing use of heroin and other illicit drugs during and after treatment. Levels of violent crime were reduced during treatment, and these remained lower than baseline levels after treatment. TOPS also reflected some of the changes in illicit drug use that were taking place in the USA at the time. Patterns of drug use among TOPS patients had changed substantially from DARP, though more than three quarters (77%) of TOPS admissions still reported opiates as their primary drug (Hubbard et al, 1989).

4.34 TOPS identified a number of differences between those starting on methadone maintenance programmes and those entering residential treatment. Patients entering residential treatment were more likely to be younger than those in the methadone maintenance group, and had more serious medical, mental health, family and legal problems. There were also differences between the patients in these two modalities in their drug use prior to treatment. Approximately two-thirds of the methadone patients reported weekly or more frequent heroin use in the year before treatment compared to only about one-third of the residential patients. The residential patients were more likely to be users of drugs other than opioids and to be multiple drug users.

4.35 Length of time in treatment was found to be one of the most important predictors of positive outcomes, with relatively long periods in treatment necessary to produce changes. Significant reductions in regular heroin use were only evident for methadone and residential patients following one year of treatment.

The Drug Abuse Treatment Outcome Study (DATOS)

4.36 DATOS was initiated in 1989 and investigated the links between patient outcome, treatment process, and programme structure. Treatment programmes were purposely chosen to represent treatment delivered in typical programmes. Intake data were collected on 10,010 adults, from 99 treatment programmes in 11 cities across the USA. Data were collected at 1 and 3 months during treatment and 12 months after treatment. The treatment programmes were: methadone maintenance, short-term residential (hospital inpatient and chemical dependency), long-term residential (therapeutic community), and outpatient drug-free treatment. The 12-month follow-up sample of 4,500 was drawn from 85 programmes, with the

follow-up stratified by treatment modality, drug pattern, impairment level, and length of time in treatment.

4.37 In DATOS, cocaine was the predominant drug. The patients treated in long-term residential, short-term inpatient, and outpatient drug-free programmes reported a 50% reduction in cocaine use at follow-up. Reductions were greater for patients treated for 3 months or more. Among the long-term residential patients, reductions in illegal activity and increases in full-time employment were related to treatment stays of 6 months or longer. The patients who remained in methadone maintenance programmes reported less heroin use than patients who left treatment.

California Civil Addict Program (CCAP)

4.38 CCAP was a 24-year follow-up study of 581 heroin addicts admitted to a treatment programme between 1962 and 1964 and who were followed up in 1974-75 and again in 1985-86. By the second follow-up point, 27.7% had died and a further 25.0% tested negative for opiates (Hser, Anglin and Powers, 1993). The strongest predictors of mortality in the study were self-reported disability, heavier drinking and smoking, and greater involvement in crime. For many of this cohort, substance use and criminal involvement continued into their 40s, and the authors concluded that the eventual cessation of heroin use is a slow process, and that for many, if they have not stopped by their late 30s, they were unlikely to do so. Predictors of ongoing substance use at the final follow-up included more polydrug use, heavier criminal involvement and low employment. Among the survivors, rates of treatment engagement were low both among the ongoing substance use and the desistance groups.

The National Treatment Outcome Research Study (NTORS)

4.39 As a result of cross-national differences in patterns of drug use, the types of treatment services provided and socio-environmental factors, it was unclear to what extent the USA findings could be generalised to different patient groups experiencing different treatment systems in different countries. It was for these reasons, that the National Treatment Outcome Research Study (NTORS) was established in the UK. NTORS was the first large-scale prospective longitudinal cohort study of treatment outcomes for drug misusers to be conducted in the UK. NTORS investigated outcomes over a 5-year period for drug dependent patients treated in one of four residential or community treatment modalities. The modalities were selected to be representative of the main treatment modalities within the UK. Residential modalities were specialist inpatient treatment, and rehabilitation programmes. The community treatments were methadone maintenance, and methadone reduction programmes.

4.40 During 1995, 1075 patients were recruited from 54 treatment programmes in England. Patients presented with a range of extensive, chronic and serious drug-related problems. The most common drug problem was long-term opiate dependence, often in conjunction with polydrug and/or alcohol problems. Many patients had psychological and physical health problems, and high rates of criminal behaviour were reported. One year after intake to treatment, outcome data were obtained for 769 patients (72%). Subsequent follow-ups at 2 and 4-5 years were conducted with a random stratified sample of patients. Clinical improvements were

found in terms of reductions in use of heroin and other illicit drugs, reduced injecting and sharing of injecting equipment, improvements in psychological health, and reductions in crime. Frequency of heroin use after one year, for example, was reduced to about half of the intake levels, and heroin use remained at this lower level throughout the full 4-5 year follow-up period. The sharing of injecting equipment was more than halved among patients who had been treated in both residential and community settings.

4.41 Rates of abstinence from illicit drug use increased among the patients from both the residential and the methadone programmes. Among the residential patients, almost half (49%) were abstinent from heroin after 4-5 years compared to around one-third of community treatment clients, and the percentage of residential patients who were abstinent from all six illicit target drugs (heroin, crack cocaine, cocaine powder, amphetamine, non-prescribed methadone and non-prescribed benzodiazepines), had increased from 1% at intake to 38% after 4-5 years. As in the American outcome studies, time in residential treatment was related to improved post-treatment outcomes. Many patients were drinking excessively at intake to treatment and although there were some improvements in alcohol use at follow-up, the changes in alcohol consumption were disappointing. Many patients were still drinking heavily at follow-up. NTORS recommended that drug treatment services should introduce or strengthen interventions specifically targeted at drinking problems among drug misusers.

Drug Treatment Outcomes Research Study (DTORS)

4.42 DTORS is the English follow-up to NTORS, using a 12-month window to assess treatment outcomes, supplemented by a qualitative assessment of 'treatment-related issues' and a cost-effectiveness analysis. In total, 1,796 drug users from 342 agencies across England were recruited – including referrals from criminal justice agencies. Where clients were recruited via the criminal justice system, there were typically more complex offending patterns, more frequent use of crack cocaine, more unstable accommodation and greater separation from the family. They were also more likely to be from BME groups. The median value of drugs used in the 4 weeks prior to treatment was £706 – and 39% reported committing acquisitive crime in this period.

4.43 Of the initial cohort, 1,131 were successfully followed up at 3-5 months and 504 at 11-13 months. From the Key Implications summary (Home Office Research Report 24, 2009), the conclusion was that DTORS outcomes were equivalent or more positive for treatment effectiveness than those found in NTORS. Employment rates increased from 9% at baseline to 11% at follow-up one and 16% at follow-up two – however, the proportion of participants classed as unable to work also increased over the course of the study follow-ups. Similarly, offending reduced from a self-reported level of 40% at baseline to 21% at first follow-up and 16% at second follow-up. The proportion of clients with children under 16 who had all their children living with them fell from 22% at baseline to 15% at first follow-up but then increased to 34% by the final follow-up. There were consistent reductions in all of the major substances assessed over the course of the follow-up periods, however, at the time of writing, these changes had not been broken down by treatment modality.

Australian Treatment Outcome Study (ATOS)

4.44 Based upon NTORS, several other longitudinal outcome studies have now been implemented. One of these was the Australian Treatment Outcome Study. Drug misusers were recruited upon entry to maintenance therapies (methadone or buprenorphine), residential rehabilitation, and detoxification; a further sample was recruited of 80 heroin users who were not currently in treatment. The study followed up heroin users for 1 year in three Australian states, and a further 2 years in New South Wales, where the majority of the cohort resided.

4.45 There were reductions in heroin use from baseline to 2-year follow-up (99% versus 35%), with this rate remaining stable to 3-year follow-up (Teesson et al, 2008). Reductions in heroin use were accompanied by reductions in needle sharing and injection-related health problems. There were also substantial reductions in criminal involvement and improvements in general physical and mental health. Positive outcomes were associated with more time in maintenance therapies and residential rehabilitation and fewer treatment episodes. As in other studies, ATOS drew attention to the importance of stable retention in treatment as a consistent predictor of superior treatment outcome (Darke et al, 2007).

Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness (ROSIE)

4.46 The Irish treatment outcome study started recruitment in 2003, and followed up 404 opiate users for three years from their entry to a drug treatment programme. The study measured drug use, involvement in crime, injecting-related behaviour, physical and mental health and social functioning among those participating in the study. Heroin use reduced from 81 per cent at the start of the programme to 47 per cent after one year (NACD, 2007). Reductions were also found for use of cannabis and cocaine. The largest reductions in drug use and involvement in crime were found during the first year and these reductions were sustained at the three-year follow-up. More participants were employed at follow-up than at treatment entry.

Drug Outcome Research in Scotland (DORIS)

4.47 The Scottish drug outcome research study was a prospective cohort study which recruited 1,007 drug misusers from 33 agencies across Scotland, including five prisons, a cohort that have not typically been included in other outcome studies and which is likely to have a significant effect on the offending profile and on the ability to offend and use drugs in this part of the sample. The study involved follow-up assessments at 8 months, 16 months and 33 months post-intake to the study, achieving a 70% follow-up rate at the 33-month follow-up point. While there are initial improvements to 8 months, these taper off at the subsequent follow-up points. The authors concluded that, compared to other community programmes, residential rehabilitation clients were twice as likely to be abstinent at 33 months, while methadone maintenance treatment was associated with reductions in heroin use but was not successful in promoting abstinence. In a paper drawn from the study, McKeganey et al (2006) reported on 695 follow-ups at 33 months and found that only

5.9% of females and 9.0% of males were abstinent from opiates in the 90 days prior to interview[17].

4.48 In an analysis of uptake of employment during the period of the DORIS study, McIntosh, et al (2008) reported that 20.1% of the follow-up sample at the final data collection point (140/695) had been in paid employment since the previous interview. The main predictors of achieving employment were being younger, having lower levels of involvement in crime, and receiving support from the treatment agency with training and education or with obtaining a job. Treatment modality was not linked to employment status. In a similar regression-based model based on the DORIS data, Bloor et al (2008) used 16-month data to assess changes in drug consumption and related outcomes. While the authors reported decreases in psychological dependence over the first 16 months of the study window, baseline levels were not linked to offending behaviour at 16 months, although current perceived dependence did relate to both substance use and offending behaviour.

4.49 Overall, the DORIS study found evidence of a strong association between substance use and crime and, consistent with other studies, reported decreases in acquisitive crime in the treatment population, but concluded that these reductions were the consequence of changes in substance use rather than a direct treatment effect on offending behaviour. This relates to an ongoing debate about the impact of drug treatment on offending and whether this is an indirect consequence of reduced drug use leading to a reduction in the need to engage in acquisitive crime. The DORIS conclusion is that the effect is primarily indirect and that treatment is impacting more on the need for income generation than directly on recidivism risks.

Overview of the Treatment Outcome Studies

4.50 A meta-analysis of drug treatment studies conducted by Prendergast et al (2002) included 78 studies conducted between 1965 and 1996. The analysis concluded that drug abuse treatment has a statistically and clinically meaningful ability to reduce both drug use and offending. The biggest predictor of crime reduction was the younger age of the samples, and, for predicting reductions in drug use, the key predictor variables were implementation fidelity of the therapeutic model, and where there was little commitment to a single theoretical approach. Treatment modality was not related to overall effectiveness although the review suggested that therapeutic communities were better suited to clients with more severe and complex drug histories. However, it is important to recognise that there are marked variations across outcome studies, not only in terms of the cultural context of drug use and treatment, but in the measures used, the methods for recruitment and follow-up and the parameters for successful outcomes. In particular, this affects what constitutes positive substance use outcomes, with threshold differences involving ongoing use of prescription drugs (such as buprenorphine and methadone), alcohol consumption and use of non-opiate drugs such as cannabis.

[17] There has been considerable debate about the definition of abstinence in outcome studies, particularly around prescribed drugs with no clear consensus on how 'abstinence' should be defined with regard to ongoing substitute prescribing.

4.51 An important feature of these treatment outcome studies is that they investigated the outcomes for patients after treatment provided in existing services under day-to-day clinical circumstances. In effectiveness research, the design is weighted towards high external validity, enabling the results to be generalised beyond the confines of the specific study, for example to other populations or settings, as is the case in the above studies. This means, however, that there were no randomisations to conditions and generally the studies did not have control groups (DARP used a 'quasi-control' group of those who dropped out after the assessment process, and a similar control approach was utilised in the Australian outcome study). The complex and complicated environment in which treatment policy is made and implemented requires this sort of information, and there is increased acknowledgment of the need for evidence of effectiveness to guide decisions about treatment policy and provision.

4.52 Cost-effectiveness and cost-benefit studies have been conducted on the data from these outcome studies. These show that when the crime-related costs of drug use were calculated, treatment was cost-effective and cost-beneficial. In most cases, the cost of treatment was recouped during treatment, and further cost-benefits accrued as a result of reduced post-treatment drug use.

4.53 The economic costs imposed on society by problem drug users are largely due to criminality, in addition to healthcare costs and lack of economic productivity. High rates of criminal behaviour are typically found prior to treatment with crime costs greatly outweighing all of the treatment costs. After treatment there was a marked reduction in criminal activity. In NTORS, the increased expenditure for treatment interventions yielded an immediate cost saving in terms of the reduced victim costs of crime, as well as cost savings within the criminal justice system. For every extra £1 spent on drug misuse treatment, there was a return of more than £3 in terms of costs savings associated with victim costs of crime, and reduced demands upon the criminal justice system (Gossop et al,1998). However, the extent of the saving may be greater depending on the profile of economic costs and benefits included in the analysis. More recently, from the English DTORS project, Davies et al (2009) concluded that there was a benefit to cost ratio of 2.5:1 from a health economic analysis and that while the net cost of structured drug treatment was £4,531, the offset savings in other health and social caring settings was £6,450.

4.54 The total economic and social cost of illicit drug use in Scotland was estimated to be just under £3.5billion in 2006. Costs associated with problem drug use accounted for 96% of the total cost, which equated to just under £61,000 per problem drug user (Casey et al, 2009). The authors have argued that estimating the economic and social costs of illicit drug use in Scotland is impeded by the lack of Scottish crime cost data that can be used in conjunction with data about crimes carried out by problem drug users.

4.55 In DATOS, Flynn et al (1999) also calculated that there were substantial economic benefits from treatment for cocaine dependence, based solely on costs of crime. These reduced costs of crime during and after treatment substantially outweighed the costs of treatment and demonstrated the value of investing in the treatment of cocaine addiction. Even without the numerous other tangible and intangible benefits that may have occurred in addition to the reductions in costs of

crime to society, the fiscal resources expended in treating cocaine-dependent patients provided a return that justified the cost of treatment.

4.56 The true cost savings to society are likely to be even greater than these crime-focussed estimates. Using the NTORS data, the changes in crime and health care consequences that were associated with specific costs of the index treatment were calculated. The most useful ratio may be the consequences related to the net change in total treatment investment. This yields a net treatment investment in the two years after intake of about £1.5 million, and a ratio of consequences to net treatment investment of 18:1 (Godfrey et al, 2002). What is suggested here is that the savings are both immediate and long-term in terms of the impact on chronic as well as acute health problems.

Bridging the Effectiveness Gap: Translating Research into Routine Practice

4.57 Carroll and Rounsaville (2007) have argued that clinical trial research has yielded a number of 'empirically supported therapies' (ESTs) in the addictions field that are widely available and have a significant evidence base, including motivational interviewing to improve retention in treatment and contingency management as an effective supplement to treatment for stimulant dependence. Yet the question they raise is why, in standard clinical practice, there is very little evidence that these interventions are commonly deployed. They argue that this is not simply a question of training or dissemination but involves complex organisational issues and greater understanding of context effects.

4.58 McLellan (2006) has referred to this as the 'research to treatment gap' and has suggested that the gap should be understood in terms of individual therapist effects (based on training, support and values), the length of the treatment available and the setting it occurs in, and the role of other key components of treatment such as medication, physical and psychological health and support or wraparound services. In response to recurring calls for studying contents of the 'black box of treatment' during the course of large-scale outcome studies in the USA (e.g. Hubbard et al, 1989; Simpson & Brown, 1999; Simpson & Sells, 1983), there has been a growing trend during the past decade for addiction treatment scientists to focus on therapeutic process, especially engagement.

4.59 This issue has been addressed in the Treatment Process Model developed by Simpson (2004). The starting point for this work is that variability in treatment outcomes can be predicted more strongly on the basis of organisational variations in the service provider than on the characteristics of the clients who access services. Large-scale national studies in the USA of relationships between organisational functioning indicators and client performance demonstrate they are interrelated (Broome et al 2007; Greener et al, 2007; Lehman et al 2002). Namely, programmes with better resources, more confident treatment staff, clearer definitions of clinical purpose and mission, open communication networks, and less stress-provoking pressures have clients who report significantly higher levels of therapeutic engagement and satisfaction with the services they received.

4.60 Recent studies show more clearly that organisational dynamics shape the attitudes of clinical staff about potential clinical innovations, with staff from well-

functioning settings more open to change and adopting evidence-based practices (Fuller et al, 2007; Joe et al, 2007; Saldana et al, 2007). There is growing recognition that implementing clinical innovations is a stage-based process and its overall strength depends on the durability of every element. Merely disseminating good ideas – especially when they are complicated or they demand special resources – is unlikely to result in their use. As Simpson (2009) has argued, it is in the services where there is better organisational functioning and more systematic and consistent implementation of evidence-based ideas that greater client engagement in treatment occurs. This in turn will lead to more active treatment participation by service users and stronger therapeutic alliances which will result in greater changes in psycho-social functioning and better treatment outcomes.

4.61 In the initial application of this work in the UK involving around 1,000 service users in the Midlands and North-West of England, Simpson (2009) found broadly similar patterns of client functioning in treatment with the exception that UK clients reported significantly poorer psychological functioning[18], while the broad pattern of worker satisfaction and organisational functioning was consistent with the findings from the USA about treatment delivery. As in the USA, there were huge variations in the effectiveness and quality of the drug treatment programmes included in the study. In a follow-up study of criminal justice clients, Best et al (2009) found that among offender populations in drug treatment there was a strong association between levels of criminal thinking and poor engagement in treatment, lower motivation to be in treatment and generally suppressed psychological and social functioning.

4.62 The key conclusion from a range of outcome studies in a wide diversity of contexts and treatment settings is that structured treatment generally results in improvements in substance use, offending, social functioning, physical and psychological health, and risk taking. Treatment effects generally take place early in the treatment process and are sustained in well implemented treatments. However, overall gains in treatment studies may mask variability in the quality of treatment with increased research emphasis on the key ingredients of effective treatment – well qualified and supported staff in a service with a clear treatment philosophy, delivering packages of evidence based care that addresses clinical needs, that provides appropriate psychosocial interventions and that provides appropriate links to 'wraparound' care in the community and to ancillary needs specific to the individual. Treatment has generally been found to more than pay for itself in terms of savings to the health and criminal justice systems as well as in improvements in personal wellbeing.

Research gaps:

- *There is a major gap in the UK literature around the variability in service quality and the technology transfer issues of delivering evidence-based treatments consistently across clients and services. While the literature would suggest clear and consistent gains in functioning amongst a wide-range of populations entering all of the main treatment modalities, there is a much*

[18] The poorer rates of psychological functioning may result from the effects of long-term prescribing treatment and limited psychosocial interventions in the UK sites (Best et al, 2009), but direct comparisons studies would be needed to test this claim.

poorer understanding of why some clients, and indeed some services, have markedly worse outcomes or how these outcomes (relating primarily to health, substance use, offending and risk) are associated with the longer-term change patterns that predict sustained recovery.

- *Linked to this, most of the outcome studies have looked at entry to a single treatment modality and have not tracked outcomes following multiple episodes or treatment pathways. This means that there is currently little research evidence on the optimal combinations of treatment.*
- *A third limitation in the outcome literature is that the focus is typically on 'front-end' treatments with little differentiation in UK studies between different types or intensities of residential programmes (and almost no comparisons between different treatment modalities), and little attempt to encapsulate the impact of either 'wraparound' or 'aftercare' (community recovery) on long-term outcomes.*
- *The outcomes literature is also limited in that none of the studies include community rehabilitation models or 'quasi-residential' treatment as a modality in spite of the increasing proliferation of such services in the UK*

Footnote: Addressing the Gaps in the Evidence Base

4.63 While the switch to a research focus on 'technology transfer' has resulted from concerns that there are significant translation problems from trial-based research studies to routine practice – and the resulting suggestion that what is required is not better evidence-based interventions but ways of actually delivering what we have in routine practice – an important footnote to this chapter is a recognition of a critical literature about the evidence base. This is best summarised in an editorial by Jim Orford (2008) who has argued that the existing literature fails to recognise that most of the evidenced psychological treatments are, at heart, the same, and that the focus on content in research has ignored key questions of context. In particular, Orford argues that the therapeutic relationship has been neglected as a research topic, compounded by a failure to recognise the importance of 'unaided change' (also referred to as natural recovery), that the study timescales have been inappropriate for a chronic condition and that, in addition to ignoring key aspects of the therapeutic relationship, broader questions of context, such as family and social circumstances, have also been ignored. Orford argues that:

> *'instead of focusing on the comparison of techniques, the focus should be upon exploring common change processes....a broader and longer-term view needs to be taken which would involve, among other things, study of treatment organisations, networks of health and social care agencies and clients' family and community settings, as well as behavioural trajectories over time.' (Orford, 2008, p5).*

4.64 This is brought into sharp focus by the analysis of treatment in Birmingham by Best and colleagues (2009) showing that clients received only infrequent contact with clinicians and that much of that time was spent on case and risk management. The challenge is to ensure that personalised treatment is delivered within a meaningful and supportive therapeutic relationship that enables and supports wider life recovery.

4.65 This echoes an argument from the mental health recovery movement advanced by Whitewell (2005) that no specific treatments are effective and that new treatments are only effective to the extent that they tap into positive expectations, contact with a support system, positive human values and the restoration of physical health. Whitewell criticises 'evidence-based practice' as a way of cleansing medicine of messy subjectivism' (Whitewell, 2005, p131). Thus, the notion that we have a gradually improving body of knowledge of what works that is imposed on a blank canvas of clients and services is a model that many recovery advocates would be unwilling to accept.

CHAPTER 5: LEARNING FROM PARALLEL FIELDS

Summary: Learning from Parallel Fields

1. There are strong parallels to learn from the mental health field where Scotland has been at the forefront of the recovery movement.
2. However, debate remains about the quality of the mental health recovery evidence base, particularly around long-term outcome studies and the effectiveness of recovery treatment systems.
3. At the heart of the mental health recovery movement is a re-drawing of the landscape characterising what services do, what the role of professionals is and what the status of the 'client' is in the recovery process.
4. The empowerment of people in recovery requires a partnership that gives families and communities a much greater and more powerful role.
5. There is a long history of community development work that is highly relevant to generating communities of recovery, based on asset development and the power of local associations and institutions to assist in the transformation of communities.
6. At the heart of this movement are the twin tenets of hope and empowerment with professionals in the role of enablers rather than experts from the criminal justice field. The normative assumption is for desistance (recovery), with the developmental criminology approach emphasising the key role of life events such as relationships and jobs in determining long-term change pathways.

5.1 In this chapter we look at some of the learning around recovery and recovery-related phenomena from other academic disciplines. While the most immediate parallel is with mental health, and this is outlined in some detail below, there are other areas of relevance that can be examined where existing work has important implications, albeit where caveats about applicability and translation must be carefully considered.

Mental Health and Recovery

5.2 Slade (2009) sets out a vision for recovery in mental health as a future:

> *'in which the goal of mental health services is more explicitly the promotion and support of personal recovery. Clinical recovery has value, as one approach to supporting personal recovery. However, a primary focus on personal recovery would fundamentally change the values, goals and working practices of mental health services.' (Slade, 2009, p40).*

5.3 Slade goes on to speak of four key dimensions of personal recovery – hope, identity, meaning and personal responsibility, while Davidson and Strauss (1992), spoke of four stages in a personal recovery journey:

1. Discovering the possibility of taking ownership and responsibility
2. Taking stock of one's strengths and limitations
3. Putting aspects of the self into action
4. Using this enhanced sense of self as a resource in recovery

5.4 *A Common Purpose: Recovery in Future Mental Health Services*, a Joint Position Paper by the Care Services Improvement Partnership (CSIP), the Royal College of Psychiatrists and the Social Care Institute for Excellence (SCIE) suggests that there is a lack of empirical evidence around recovery in mental health. The Position Paper asserts that:

> *'The recovery literature has arisen largely from personal experience with more recognisably scientific evaluation and theory following later, and although rich in personal meaning it remains light on systematic analysis.' (Care Services Improvement Partnership et al, 2008, p5)*

5.5 However, it suggests that this may be intrinsic in an approach that celebrates the individuality of the pathways to personal recovery and a tradition that is based on the writings of people experiencing that recovery journey. Nonetheless, the paper cites evidence (Calabrese and Corrigan, 2005) on psychotic conditions where high levels of recovery and improvement (50% to 75%) are demonstrated over lengthy periods of time (20 to 35 years) with outcomes of improvement including independent living and the absence of symptoms of illness.

5.6 Similarly, Harding et al (1987) conducted a 32-year follow-up study of the most difficult to place third of a population of psychiatric in-patient residents – at the follow-up point 81% were able to look after themselves. Twenty-five percent were fully recovered and 41% showed significant improvements, while only 11% of people with severe and enduring mental illness did not show any improvement and remained within the treatment and support system. More recently Warner (2010) reviewed the evidence of recovery and reported, from over 100 studies, that 20% of schizophrenics make a complete recovery and 40% a 'social recovery' (defined as economic and residential independence and low social disruption), with work and empowerment two of the key features of the recovery process.

5.7 Among the key themes set out in *A Common Purpose* was a shift in emphasis from a pathology model to one with an increasing focus on hope, strength and wellbeing; a process of empowerment for people in recovery; the central role of social inclusion and the discovery of a sense of personal identity. The focus on services was about the need for individualising treatment and the need for staff to offer a caring and personal focus to those in recovery. The report also suggested that:

> *'in order to support personal recovery, services need to move beyond the current preoccupations with risk avoidance and a narrow interpretation of evidence-based approaches towards working with constructive and creative risk-taking and what is personally meaningful to the individual and their family.' (Care Services Improvement Partnership et al, 2008, p6)*

5.8 This is consistent with the findings of Kirkpatrick et al (2001) that professionals who project messages of hope are a greater help to their clients, and that clients confer extra value on professionals who are seen to go the extra mile and to act in the role of a critical friend (Berg and Kristiansen, 2004). This supplements the key finding by Norcross et al (2002) that the relationship between client and

therapist accounts for the largest amount of variance in outcomes that is not accounted for by pre-admission client characteristics.

5.9 For the Scottish Recovery Network, Brown and Kandirikirira (2007) used a recovery narratives model as part of a methodology that acknowledges the uniqueness of the lived experience of people in recovery, and identified a range of both internal and external elements involved in recovery process. The internal elements included:

- self-belief
- belief that recovery is possible
- meaningful activities in life
- positive relationships
- an understanding of the illness
- active engagement in recovery strategies.

5.10 The external factors included:

- supportive friends and family
- being told recovery is possible
- being valued
- having responsive formal support
- living and being valued in the community
- having life choices accepted

5.11 Defining a clear sense of self was seen as being as important as managing or overcoming symptoms. This sense of identity transformation was linked to the idea of finding value in the self and being valued by others. While the narrators were generally positive about services, there was a perception that services need to be more responsive to the diverse and changing needs of people. This includes supporting people to make choices and take risks as part of a move towards self-determination.

5.12 Also in the Scottish context, Shinkel and Dorrer (2007) have identified some key areas of recovery oriented culture change that have potential application in the addictions field, relating to workers' attitudes and beliefs about the recovery prospects of their clients:

- belief in and understanding of recovery
- respectful relationships
- focus on strength and possibilities
- care and support directed by the service user
- participation in recovery of significant others
- challenging stigma and discrimination
- provision of holistic services and supports
- community involvement

5.13 To this end, Thornicroft (2006) has identified key strategies for promoting empowerment of service users:

- ensure full participation in formulating care plans
- provide access to Cognitive Behavioural Therapy (CBT) to address negative self-stigma
- create user-led and user-run services
- develop peer support worker roles in mental health services
- advocate for employers to give positive credit for experiences of mental illness
- support user-led evaluations of treatment and services

5.14 *Key learning points from mental health and recovery:*

1. *Recovery is possible and takes place across large numbers of individuals.*
2. *Recovery is likely to be linked to empowerment and to engaging in meaningful activities.*
3. *Developing a sense of agency and self are critical to this process.*
4. *Hope is central to the process of recovery, and it is essential that workers do what they can to support and transmit optimism and empowerment and that they are seen to 'go the extra mile'.*

Alcohol and Recovery

5.15 Much of the key literature on recovery and alcohol has been addressed in Chapter 3 of this report. In one of the earliest outcome cohort studies, Vaillant (1993) reported on an 18-year follow-up of a sample of 106 problem drinkers finding that 39% were abstinent at the final follow-up point – but Vaillant pointed out, as Laub and Sampson (2004) have done in relation to crime careers, that changes are not always predictable and that it is the dynamics of life course transitions and turning points (such as opportunities for work, for new relationships, for parenting and for new places to live and communities to live in) that determine long-term outcomes to a much greater degree than risk or protective factors in childhood or adolescence.

5.16 In a study of long-term remission among treated and untreated problem drinkers, Moos and Moos (2006) reported a 62% remission rate in helped drinkers compared to 43% in the drinkers who did not seek help from treatment services. In the untreated group, those who improved had more personal resources and fewer alcohol-related deficits, leading the authors to conclude that:

> *'the likelihood of relapse rises in the absence of personal and social resources that reflect maintenance factors for stable remission.' (Moos and Moos, 2006, p219)*

5.17 Much of the work on alcohol recovery has focused on 'natural recovery', also referred to as auto-remission, in which individuals complete their recovery journeys without recourse to formal treatment engagement. Using population survey methods, Sobell, Campbell and Sobell (1996) reported rates of 75% and 77% recovery without formal help in former problematic drinkers. In a further Canadian study based on population survey data, Cunningham (2000) also assessed natural recovery rates for a range of substances other than alcohol, and reported that the use of any formal treatment ranged from 43.1% for cannabis to 90.7% for heroin, with 59.7% of cocaine users seeking formal treatment at some point in their recovery

journeys, providing epidemiological evidence that, at a population level, the majority of people overcome a range of alcohol and drug problems without recourse to specialist treatment provision.

5.18 Bischof et al (2001) analysed general population surveys in northern Germany to compare current alcohol-dependent drinkers with remitters who had sought no formal help and found that the remitters had a later onset of dependence and had fewer years of dependent drinking, but higher average daily alcohol consumption than the treatment seekers in the period prior to treatment seeking. The authors also found that the remitters were more likely to live in a stable relationship and be more satisfied with work and with their financial situation.

Community Engagement and Recovery in the Community

5.19 At the heart of work done around the concept of community engagement or development has been the concept of 'empowerment' defined by Zimmerman and Rappaport (1988) as:

> *'a process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community.' (Zimmerman and Rappaport, 1988)*

5.20 One of the key principles that has been emphasised by community engagement writers is that empowerment is for the individual and the community, and Perkins et al (1990) have argued that it is essential that empowerment has a collective orientation, that it is inclusive and evolving as the community grows and shifts.

5.21 Baldwin (1987) has outlined what he sees as core principles for effective community development which include: asking community members to identify the geographic boundaries of their communities; compiling a neighbourhood resources directory and a linked directory of workers who are based in that community; developing action plans for each community and target; and focusing on community members' quality of life as experienced as a core outcome indicator.

5.22 One of the core texts in this field – *Building Communities from the Inside Out* (Kretzmann and McKnight, 1993) has described the Asset-Based Community Development model (ABCD). The ABCD model is based on the idea that the resources needed to develop a community are already there within it in terms of individuals, associations and organisations and that the solutions to local community problems do not result from increasing involvement of more professionals from outside. Indeed, Kretzmann and McKnight argue that external resourcing is not enough and that:

> *'it needs to be realistically recognised that if all the outside resources did suddenly begin to be available in low income neighbourhoods, without an effective and connected collaboration of local individuals, associations and institutions, the resources would only create more dependency and isolation before they were finally dissipated.' (Kretzmann and McKnight, 1993, p374)*

5.23 Applying this to drugs recovery, this would suggest a 'bi-productionist' approach where, at least in the initial stages, drug users in recovery will need effective links and supports from local agencies and institutions and empowerment will be a gradual but planned process. It is not simply the case of handing over power and resources without condition.

5.24 The mechanism that Kretzmann and McKnight propose is an inventory of the skills and capacities of local people, supplemented by engagement with local associations and institutions with local associations seen as having a key role in empowering individuals, building strong communities, creating effective citizens and making democratic activities work. Additionally, they see a key role for local organisations like hospitals, the police, schools and the local authorities in economic regeneration through:

> *'local purchasing, hiring locally; developing new business; developing human resources; freeing potentially productive economic space; local investment strategies; mobilising external resources and creating alternative credit institutions.' (Kretzmann and McKnight, 1993)*

5.25 But the core of their model is to ensure that the drive for change and regeneration originates within the community. For recovery groups, this will involve identifying the interests and the skills of those in recovery and allowing them the support and access to resources to provide the basket of recovery groups required.

5.26 This area of work has also addressed the question of the role of professionals in community development work. Gottlieb (1982) reported that the most appropriate forms of professional engagement in community activities were indirect, involving consultation and referral, with much less support for more direct forms of professional engagement. While some form of professional help was welcomed by most community members in Gottlieb's work on self-help groups, autonomy was highly valued by the groups with considerable group commitment deriving from self-direction from group members. As Levine (1988) has argued, the criteria for effectiveness of community projects are different from those of professional bodies, and professionals will frequently need to 'learn' about the self-determining and voluntary nature of self-help community activity before they can make a positive contribution. Orford (1992) has argued that there is a culture change required by services and staff if they are to be sensitive to community groups and to support the transition of community members to maximise effects.

5.27 What is clear is that the community can play a significant role in supporting treatment gains. Using a randomised design to assess the effectiveness of the Community Network Development Project for mental health clients, Edmunson et al (1984) compared standard aftercare to developing a support system of community champions and volunteers. At 10 months after treatment, rates of re-hospitalisation were lower by 50% (17.5% compared to 35%) in the group assigned to community support and self-help groups.

5.28 Furthermore, reviews of studies comparing professional workers and volunteers have tended to favour the latter group as help agents. In a review of 42 studies conducted by Durlak (1979), involving psychiatric in-patients and out-

patients, 28 studies showed no outcome differences between professional and 'paraprofessional' help across a range of psychiatric conditions. In only one case did a study find in favour of the professionals and 12 studies suggested better outcomes when help was provided by paraprofessionals (the final study had mixed findings). Although this study has been subjected to subsequent challenge, Hattie, Sharpley and Rogers (1984) conducted a meta-analysis of the studies reviewed by Durlak, with the analysis concluding that:

> *'on the whole, paraprofessionals are more effective than (or at least as effective as) professionals.' (Hattie, Sharpley and Rogers, 1984, p536)*

5.29 As to why self-help groups may offer something that professional support cannot, Orford (1992), in a review of a diverse range of community groups not linked specifically to addiction or mental health, has suggested eight key functions of self-help organisations:

- emotional support
- the provision of role models
- a powerful ideology
- relevant information
- ideas about ways of coping
- the opportunity to help others
- social companionship
- a sense of mastery and control

5.30 *Key learning points from community development work:*

1. *Communities are where recovery takes place in the long term and communities themselves will have a recovery journey.*
2. *The focus should be on strengths in the community based on an inventory of assets categorised (individual skills and resources, associations and institutions in that locality).*
3. *There is empirical support for the capability of peers and volunteers in delivering community-based programmes effectively.*
4. *Communities have a key role to play in sustaining and enhancing treatment gains.*
5. *There are a wide range of functions that community groups can play in the recovery journey, that are both dedicated to overcoming addictions and to broader social growth.*

Positive Psychology and Social Inclusion

5.31 The ideas that provided the foundations for community psychology have more recently been supplemented by the work of Martin Seligman around 'positive psychology' (Seligman, 2003). This has signalled a switch from a pathology model to one based on hope, spirituality, empowerment, connection, self-identity and purpose. In this model, positive living – which would be the aim for recovering drug users and for those with mental health problems – is around living an engaged life of fulfilling potential and having a positive sense of meaning and identity, irrespective of the management of symptoms.

5.32 It is the ethos of this framework that is so important and the transition it implies for methods and approaches to both research and intervention. Seligman (2003) argues that:

> *'Psychology as usual is about repairing damage and about moving from minus six up to minus two. Interventions that effectively make troubled people less so are usually heavy-handed, and the balance between the exercise of will and the push of external forces tilts towards the external. .....Building strengths and virtues and using them in daily life are much a matter of making choices. Building strengths and virtue is not about learning, training or conditioning, but about discovery, creation and ownership.' (Seligman, 2003, p136)*

5.33 Thus, the key to a positive method is not the focus on pathology but the expression of strength, even in the presence of significant difficulty.

5.34 This notion of building on personal resources is consistent with the focus of meaningful activities within the social inclusion work model, and is predicated on the social constructionist idea that the growth of key self-concepts – esteem, efficacy, identity and management – are underpinned by interpersonal activities and social engagement. Carew, Birkin and Booth (2010) have argued that:

> *'The experience of being in work is not only beneficial for individuals but also has broader benefits for families and communities…..Having a parent in work improves the life chances of children. Work influences the prosperity of communities and enables greater social cohesion.' (Carew, Birkin and Booth, 2010, p28)*

5.35 Davis (2010) has gone on to argue that professionals have a key role to play in this social inclusion and community development agenda. He has argued that:

> *'people in society who have the power to exclude must firstly understand and value the identity and experience of excluded people and secondly, work with them and society to share hope, promote choice and create opportunity.' (Davis, 2010, p33)*

5.36 Thus, social inclusion relies on collaborative relationships between professionals and communities to empower and enable – but not to direct or control.

Criminal Careers and Long-Term Desistance

5.37 The relevance of the criminal justice perspective to recovery concepts is around what has been termed the 'lifecourse' or developmental model of criminology which has attempted to map changes over time. Within this perspective, Thornberry (2005) has argued that:

> *'the advent of developmental life-course theories of delinquency is perhaps the most important advance in theoretical criminology during the latter part of the twentieth century.' (Thornberry, 2005, p156)*

5.38 In this approach the key factors to be understood are onset, course and desistance, with much of the evidence deriving from longitudinal studies.

5.39 The most important work within this tradition is *Shared Beginnings, Divergent Lives* (Laub and Sampson, 2004) which provides follow-up data to the age of 70 of a cohort of young male offenders initially recruited and identified in the teenage years. In other words, this is a 55-year cohort follow-up study which assessed the longitudinal predictors of desistance from crime. Laub and Sampson concluded that the key determinants of long-term change were:

- attachment to a conventional person (spouse)
- stable employment
- transformation of personal identity
- ageing
- inter-personal skills
- life and coping skills

5.40 They found that:

> *'the stronger the adult ties to work and family, the less crime and deviance among both delinquents and non-delinquent controls.' (Sampson and Laub, 2005, p15)*

5.41 The long-term outcomes from their study would suggest that desistance is the eventual pattern for all men. There are two key inferences that can be drawn from this list – the first is the omission of any criminal justice interventions or techniques and the second is the relatively low importance of adolescent risk factors.

5.42 This theme has been picked up in a more recent study by LeBel and colleagues (2008) in their attempt to differentiate between 'subjective' and 'social' factors in criminal desistance. In essence, the challenge they attempted to address was whether work and stable relationships are symptoms of already established changes in values and beliefs about offending, or whether getting married and/or finding suitable and stable employment act as catalysts for changes in beliefs about offending and commitment to mainstream values. Both positions, however, accept the premise that it is changes in 'social capital' – the stake the offender has in conventional society – that will determine desistance from offending. The authors conclude that both types of change are essential but that causal ordering cannot be determined at this stage.

5.43 As identified by Hser and colleagues (2007), based on longitudinal data to examine predictors of desistance in heroin users followed up over a 33-year window using the CCAP data described in Chapter 4, self-efficacy and psychological wellbeing were the clearest predictors of stable recovery. Hser and colleagues emphasise key developmental concepts such as trajectories and turning points that have been used extensively in the study of crime careers, although they concede that there is a dearth of information about cessation factors. One of their observations is that career pathways appear to differ for different substances, with cocaine use increasing through the 20s to early 30s and then declining but heroin use continuing to increase. In terms of the typology of heroin users developed by

Hser and colleagues, the authors differentiate between stable high-level users, decelerating users and early quitters. The last group (who constituted just under half of their longitudinal sample) had heroin careers of typically less than ten years. This early quitting population of heroin users had higher frequencies of use in the first 2-3 years of use but then showed marked reductions and were abstinent by year 11.

Overview and Interpretation

5.44 The most immediate area for learning – and for pragmatic co-working - is around recovery and mental health, where Scotland has been at the forefront of the development of a recovery movement. The key concepts of changes in culture and working practice, the increased empowerment of the service using population and their active involvement in self-determination on an individual and group basis, the transition to assertive community approaches and the development of peer-led recovery communities are all likely to be essential elements of the recovery movement in the drugs field. The gradual emergence of an evidence base in this area – predicated on different academic values and approaches, such as the prioritisation and emphasis on narrative and the deployment of qualitative methods – are areas that need to be examined closely in developing a recovery evidence base in the addictions field.

5.45 Likewise there is an evidence base around community working that is well established and which has traditionally used the more quantitative techniques of academic psychology to evidence both individual and epidemiological markers of recovery. However, there are 'translation' problems for both of these fields and replications and testing are required to map the appropriate areas for cross-learning. Nonetheless, the recovery movement in mental health in particular, has mapped out the territory that requires to be assessed and has provided both data and techniques that will inform the evolution of an equivalent evidence base for drug recovery in Scotland.

CHAPTER 6 – ANALYSIS OF THE EVIDENCE CITED IN THE ROAD TO RECOVERY AND LITERATURE REVIEW

Summary: Learning from the Literature Review

1. For criminal justice populations, there is international research support for the effectiveness of therapeutic communities in prison and continuity of care on release. UK studies have provided some support for quasi-coercive interventions, with effects varying depending on implementation and delivery factors.
2. Around families, there is considerable empirical support for family engagement in treatment with evidence of improved outcomes for the individual in treatment and improved functioning within the family. Positive results have also been shown for parenting training and for specialist interventions for pregnant drug users.
3. Although the evidence on recovery for adolescents is limited, there is some support for improved outcomes resulting from mutual aid engagement by adolescents.
4. Within a broad framework of developing recovery capital, there is clear support for the effective use of recovery housing, training and vocational support as parts of a recovery package of care.
5. While there is some empirical support for integrated treatment, the evidence base around co-morbidity and recovery remains limited.
6. While there is some support for specific psychological or psychosocial interventions, there is increasing evidence that the context of treatment (in particular, the therapeutic alliance and the level of client engagement) is an equally important predictor of treatment outcomes, with worker motivation and efficacy central to this effect.
7. Effective continuity of care is essential with an increasing international evidence base around the benefits of assertive linkage to aftercare and community support and for the use of recovery management check-ups.
8. There is a strong and consistent evidence base around the benefits of engaging in mutual aid and ongoing support.

Introduction

6.1 This chapter provides analysis of the evidentiary foundation of *The Road to Recovery* strategy and a review of the published literature on recovery as it relates to drug misuse. This is done in two stages as set out below:

- An appraisal of the evidence sources cited in the report; and
- A review of the published literature.

6.2 Full descriptions of the methods used for each of these stages are set out in Chapter 2.

Analysis of the Evidence Cited in *The Road to Recovery*

6.3 The strategic direction of *The Road to Recovery* is predicated on a range of key policy and guidance documents, some of which are specific to drug misuse and others which have a broader remit. In order to identify the research strengths and

gaps and to inform further investigation, the key sources cited within *The Road to Recovery* were analysed and an appraisal made on the evidentiary foundation of each, how they relate to recovery and their relevance to Scotland. In total 30 documents were reviewed; it is important to note that many of these sources relate to policy documents rather than research or guidance documents. These are summarised here under the thematic headings used within *The Road to Recovery* and throughout this chapter. These are:

- Criminal justice and prisons.
- Families and children.
- Prevention and education.
- Treatment and intervention.
- Making it work.

6.4 Summary reviews of each of the documents are set out in Appendix 1.

Criminal justice and prisons

6.5 Chapter 4 in *The Road to Recovery*, Law Enforcement, sets out the government's approach to addressing the supply of illegal drugs, promoting recovery through criminal justice interventions and reducing or stabilising drug misuse amongst prisoners.

6.6 The evidence base for addressing the supply of illegal drugs was provided by the Serious Organised Crime Agency with supplementary information on seizures and international markets provided by available Scottish Government statistics. By the nature of this information and the surveillance undertaken to collect and collate this data it is unclear the extent to which gaps exist. For these reasons this report makes no further comment on this area.

6.7 *The Road to Recovery* sets out the range of criminal justice interventions now provided in Scotland, including Arrest Referral, Mandatory Drug Testing, Drug Courts and Drug Treatment and Testing Orders (DTTOs). Two cited studies provide evidence of effectiveness on pilot studies of Drug Courts and DTTOs.

6.8 Chapter 4 in *The Road to Recovery* also addresses the issue of drug problems in prisons. The key evidentiary source used in this section is the national offender management strategy, *Reducing Re-offending: National Strategy for the Management of Offenders* (Scottish Executive, 2006e). This sets out a target of 2% reduction in reconviction rates in all types of sentences by March 2008. Its focus in achieving this is on inter-agency working for sharing of resources, expertise and information.

6.9 The strategy notes the gaps in current research, asserting that *"We would understand more about the effectiveness of work with offenders if more of the data available came from studies which track individuals through the system rather than from statistical snapshots" (p28).*

6.10 The strategy also suggests that data should examine the rates of re-offending and the seriousness of offences.

6.11 The SPS Prisoner Survey 2007 (SPS, 2007) cited in *The Road to Recovery* was repeated in 2008 (SPS, 2008). While providing good, relevant data on the prevalence of drug use and drug problems at intake it does not provide information on the nature, quality or continuity of drug treatment in prisons, nor about ongoing needs for recovery in and after prison.

Families and children

6.12 Chapter 5 in *The Road to Recovery*, Getting it right for children in substance misusing families, opens with the statement that, "Current best estimates indicate that 40,000-60,000 children may be affected by parental substance misuse. It cites *Hidden Harm: Responding to the needs of children of problem drug users* (ACMD, 2003) as the source for this estimation, which was itself derived from data from the DORIS study (see Chapter 4) combined with estimates of problem drug use prevalence. Calculations based on these sources also estimate that there are between 10,300 and 19,500 children in Scotland who are living with a problem drug user (p27). These figures are based on a retrospective analysis of existing datasets yet remain the key evidentiary foundation of prevalence in Scotland.

6.13 There are two main sources used for epidemiological estimation - the ACMD (2003) report 'Hidden Harm' estimated that there were between 250,000 and 350,000 children of problem drug users in the UK, representing 2-3% of all under-16 year olds, while the 2004 Alcohol Harm Reduction Strategy for England estimated that there were 780,000 to 1.3 million children living with adults with an alcohol problem. However, it was recognised that there are limitations to both of these estimates.

6.14 More recently, Manning et al (2009) used a secondary data analysis method based on household surveys conducted in the UK, including the Scottish Crime Survey (2000) which showed that 1% of children (around 12,000 children) had witnessed force being used against an adult in the household by their partner whilst drinking alcohol and 0.6% (almost 6000 children) whilst using drugs. The authors concluded that around 8% (up to 978,000) of children lived with an adult who had used illicit drugs within that year, 2% (up to 256,000) with a class A drug user and 7% (up to 873,000) with a class C drug user. Around 335,000 children lived with a drug dependent user, 72,000 with an injecting drug user, 72,000 with a drug user in treatment and 108,000 with an adult who had overdosed. Elevated risk of harm may exist for the 3.6% (around 430,000) children in the UK who live with a problem drinker who also uses drugs and where problem drinking co-exists with mental health problems (around 500,000).

6.15 According to the ACMD Hidden Harm report (2003), parental drug use can compromise a child's health and development from conception onwards. Parental substance misuse has been associated with genetic, developmental, psychological, psychosocial, physical, environmental and social harms to children (ACMD, 2003; ACMD, 2006; Barnard and McKeganey, 2004; Jaudes et al, 1995). The unborn child may be adversely affected by direct exposure to alcohol and drugs through maternal substance use (Eyler and Behnke, 1999; Guerrini et al, 2007; Huizink and Mulder,

2006). The risk is contingent on the age of the mother, nature and patterns of substance use and context (Suchman and Luthar, 2000). Inadequate monitoring, early exposure to substances, positive role modelling of drugs and the failure to provide a nurturing environment can influence the likelihood of use. The limited research attempting to unveil the types of harm associated with parental substance misuse is largely restricted to retrospective cohort studies. Much of this work has attempted to identify adverse childhood experiences (ACEs) in the context of parental alcohol misuse among unhealthy/disordered adult populations (Kestila et al, 2008; Zlotnick et al, 2004).

6.16 The Hidden Harm report cites the death of a child living with a problem drug user as evidence on the risk to children in substance misusing families. There is no research cited which addresses the prevalence and nature of non-fatal harm to children across Scotland.

6.17 The focus of the remainder of Chapter 5 in *The Road to Recovery* moves to policy, guidance and practice relating to the identification and protection of vulnerable children. The only other evidence source directly cited in this chapter is the Scottish guidance document, *"Getting it right for every child in kinship and foster care"* (Scottish Executive, 2007).

6.18 *Getting it Right for Every Child* followed a series of publications at Scottish and UK level since 2002. These publications are set out in Table 6.1 with reference to their evidentiary foundation and research gaps identified. Research gaps identified within the reports are highlighted as quotations as opposed to those gaps identified by the research team which are presented in normal text. The information presented here highlights the lack of evidence base underpinning recent policy and guidance and the identified research gaps.

Prevention and education

6.19 Preventing Drug Use (Chapter 2) in *The Road to Recovery* cites 11 sources of evidence. The first four of these (p12) relate to the association between drug misuse and deprivation and a further three make brief reference to the links between drug misuse and mental health problems, homelessness and alcohol problems. There is no evidence presented on the prevalence of problems or the effectiveness of prevention and education strategies in these populations.

6.20 The prevalence of drug use amongst Scottish school children is cited from the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS, 2006). The remaining three sources of evidence relate to the effectiveness of drug education in Scottish Schools and the joint Scottish Government and COSLA policy statement on early years and early intervention.

6.21 The study into the effectiveness of drug education in Scottish schools was conducted by University of Stirling and University of Edinburgh in 2005 and published in 2007. The methods included a literature review, a postal survey of schools, sample observations in schools and qualitative research with young people. A total of 100 classroom observations were carried out.

Table 6.1: Summary of documentary evidence chain on Families and Children

Year	Evidence source	Evidence type	Information gaps
2002	It's everyone's job to make sure I'm alright: Report to the Child Protection Audit and Review (Scotland)	Case audit of 188 child protection files which yielded 11 interviews with children; analysis of Childline and Parentline calls; MORI Scotland survey of public knowledge and understanding of child protection system; questionnaire survey of academics, statutory and voluntary agencies and MSPs.	Insufficient needs assessment of newborn children of substance using parents and parents with a history of neglect.
2003	Hidden Harm. Responding to the Needs of Children of Problem Drug Users (U.K)	Witness testimony; secondary data analysis on prevalence; survey analysis of treatment, maternity and social services. Survey had overall response rate of 55%.	*'A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from conception to adolescence'*.
2003	Getting Our Priorities Right: Good Practice Guidance for Working with Children and Families Affected by Substance Misuse (Scotland)	No up-to-date data presented.	No clear presentation of evidence and no research about implications on recovery for individuals or families.
2004	Hidden Harm – Scottish Executive Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs (Scotland)	No up-to-date data presented.	Need for improvements in data collection, training for workers and integration between drug services, children's services and child protection services. Particular emphasis in the report is placed on criminal justice and the potential role of Drug Treatment Testing Orders (DTTOs) in targeting women offenders.
2004	Protecting Children and Young People: Framework for Standards (Scotland)	No up-to-date data presented.	*'Taking account of the needs of the child and their parents, professionals, working together'* (p17) to focus on needs and risks, personal and family strengths, support networks and resources available; and the research and information gaps that need to be filled and the resources and options to fill them.
2006	Hidden Harm - Next Steps: Supporting Children - Working with Parents (Scotland)	Policy update document. No up-to-date data presented.	Although recommendations are laid out, little indication of effective practice and examples of success.
2007	Looked After Children and Young People: We Can and Must Do Better (Scotland)	No up-to-date data presented.	Care Commission tasked to review the health of looked after children and young people. Focus on partnership approaches *"with local authorities to deliver a more robust and comprehensive data collection and reporting*

			framework" (p16).
2007	Getting It Right for Every Child in Kinship and Foster Care (Scotland)	No up-to-date data presented.	There is little focus on recovery or its impact on the family within the document and no presentation of up-to-date evidence.

Table 6.2: Further sources – Prevention and education

Year	Evidence source	Evidence type	Information gaps
2002	Evaluation of the 'Know the Score' Drugs Campaign	80 interviews with representatives of organisations involved; 8 workshops involving 140 participants; survey of Drug Action Teams and secondary analysis of data on enforcement, publicity, and campaign activities.	Evaluation limited by *'lack of specificity, or measurability of the objectives of the campaign'*, the absence of a baseline and locally set objectives (p30).
2006	Review of Choices for Life (Scotland)	Survey data supplemented by discussion groups and in-depth interviews with teachers. Pre and post intervention assessments using qualitative and quantitative methods with large sample size (around 1,700 at each time point) – but no follow-up assessment of impact on behaviour.	No outcome analysis to assess impact on drug uptake in secondary school; authors concluded that *'there was limited follow-up education to capitalise on (this) interest'* (p7). Authors recommended that the views of participants are taken at intervals as they progress through school. *'Over the long term, this would allow actual behaviour to be related to attend (sic) at Choices events rather than relying on current perceptions of future behaviour'* (p31)
2006	Pathways to Problems; Hazardous Use of Tobacco, Alcohol and Other Drugs by Young People in the UK and Its Implications for Policy (UK)	None – review of existing information. Not a systematic review; expert testimony to ACMD group consisting of a range of eminent practitioners, policy makers and academics.	Report identified need for large scale periodic surveys of 11-15 year olds; a longitudinal study or a representative group of 15-30 year olds and improved evidence on good parenting and stable family life. *'In the light of the evidence that classroom-based drugs education has very limited effectiveness in reducing rates of drug use, there should be a careful reassessment of the role of schools in drug misuse prevention'* (p12).
2007	Review of Research on Vulnerable Young People and their Transitions to Independent Living (Scotland)	Review article Not a systematic review – described by the authors as 'a thorough scoping exercise', including published and 'grey' literature.	*'There are not any long-term studies in Scotland on outcomes for young people leaving care. There are, therefore, no studies which attempt to disaggregate the impact of individual factors and interventions on young people'* (p11). Review does not mention the impact of recovery on effective transitions.

6.22 The study concluded that*, 'Overall, it is clear that there is much good practice in Scotland in drug education, but more can be done to enhance its effectiveness, particularly through clearer guidance on evidence-based methods and approaches, and on continuity and progression; further training and support to boost teachers' knowledge, skills and confidence; and more attention to resources'* (p204).

6.23 The joint Scottish Government and COSLA policy statement on early years and early intervention provides a framework for a strategic approach to the early years prioritising resources across local government, the health service and the public sector.

6.24 The document contains no up-to-date data. The focus on capacity building in individuals, families and communities and on maximising life chances is consistent with a recovery model and has an emphasis on 'what works and on evidence-based approaches'. However, it is not made clear how this will be done and what the link to adult or community recovery will be – the document does not have vulnerable parents as a target.

6.25 The authors identified and reviewed a further four reports which are relevant to the scope of this work. These are summarised in Table 6.2 with fuller detail in Appendix 1.

Treatment and intervention

6.26 *Promoting Recovery* (Chapter 3 of *The Road to Recovery*) sets out the evidence framework which underpins a multi-agency system of treatment and care in Scotland including drug services, mental health services and training and employment services. The key sources of evidence are discussed here with a more detailed analysis of each set out in Appendix 1.

6.27 *Mental Health in Scotland: Closing the Gaps – Making a Difference: Commitment 13* was produced in 2007 by the Mental Health and Substance Misuse Advisory Group, Scottish Government. Evidence was collected through a literature review and contributions from an expert advisory group. It provided recommendations for care and support for people with co-occurring substance misuse and mental health problems. Data on the extent of the need appears to be UK-wide or English-focused, with small-scale studies in Glasgow.

6.28 The data from the service user survey implies that current drug treatment services are not responsive to the needs of people with mental health problems since this group tend to abuse alcohol, cannabis and cocaine rather than opiates.

6.29 There remains a lack of clear evidence for Scotland (outside Glasgow) as to the extent of co-morbidity of mental health problems and substance misuse. There is also a gap in knowledge around the usage patterns of people with mental health problems.

6.30 *Drug Misuse and Dependence: UK Guidelines on Clinical Management* was produced by a UK expert working group in 2007. It is intended for all clinicians in the

UK, especially those providing pharmacological interventions for drug misusers as a component of drug misuse treatment.

6.31 The document highlights a number of gaps in the evidence base for drug treatment research and so this is obviously important in terms of 'recovery'. However, the publication mainly deals with pharmacological interventions.

6.32 The guidelines state: *'Although the evidence base for drug misuse treatment has improved, the working group found that, in many areas of drug treatment, evidence was either lacking or was based on research from countries other than the UK'* (p10).

6.33 The evidence suggested that methadone is more likely to retain patients in treatment, but the evidence for the relative effectiveness of methadone and buprenorphine at preventing illicit opioid misuse is mixed – further research is required.

6.34 Since the advent of supervised consumption, the number of drug-related deaths involving methadone has reduced, during a period when more methadone is being prescribed, providing indirect evidence that supervising the consumption of medication may reduce diversion although further is research required.

6.35 Evidence for the effectiveness of take-home naloxone in preventing overdose-related deaths in opiate misusers is largely anecdotal at present.

6.36 *National Quality Standards for Substance Misuse Services* were produced by Scottish Executive in 2005 to set out a framework of standards to ensure consistency in the provision of all substance misuse services.

6.37 The standards have been developed from the standpoint of the people who use these services. They describe what each person can expect from the service provider. They focus on the progress that the person using the service can make during a period of treatment.

6.38 There is no evidentiary base cited within this document. There was a limited level of consultation with service providers and users consisting of local workshops.

6.39 The *National Investigation into Drug-Related Deaths in Scotland, 2003* was conducted in 2005 to investigate and report on causes and circumstances of drug-related deaths in Scotland. Data on the 317 drug-related deaths in Scotland in 2003 were collected from the General Register Office for Scotland (GROS), police, prisons, Crown Office, primary care, mental health services, criminal justice services and drug services. In addition, primary research was conducted with overdose survivors sampled from Glasgow and fatal overdoses were compared with data from London coronial courts.

6.40 The study found that nearly half of all deaths occurred when other people were present and demonstrated a clear reluctance in those present to call for help. Most deaths involved more than one drug and over half involved alcohol. *The Road to Recovery* notes that this position remains largely unchanged.

6.41 In addition to the evidence sources cited in *The Road to Recovery* a further three relevant official documents were identified by the authors and are considered in Table 6.3 with fuller detail in Appendix 1.

Table 6.3: Additional evidence sources relevant to 'Treatment and Interventions'

Year	Evidence source	Evidence type	Information gaps
2006	Workforce Plus – An Employability Framework for Scotland	Strategy document. No up-to-date data provided.	*'There is some evidence that support for disadvantaged clients are too short term and expertise often lost between the end of funding for one project to the start of another'.* *'There is a perception that the needs of some groups are met in a way that separates them unnecessarily from other groups'.* *'Existing services tend to focus on the job ready and there are gaps in current provision, particularly in terms of early engagement and in-work support'* (all p47).
2007	Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008 - 2011	Strategy document. No up-to-date data provided.	Action 4 requires *'Improvement of attitudes and behaviours within staff groups'* (p12). Action 5 includes a requirement to make effective linkages to other key public health agendas including alcohol and drugs.
2008	Hepatitis Action Plan for Scotland, Phase II: May 2008 – March 2011	Action Plan. No up-to-date data provided.	Over 85% of the individuals infected with Hepatitis C are infected through the use of needles. The action plan proposes to reduce the re-use and sharing of needles among these individuals by promoting safer injecting. However, this may encourage these individuals to continue injecting and thus make the process of recovery more difficult.

Making it work

6.42 The final chapter in *The Road to Recovery* sets out how the Scottish Government intends to work with all relevant partners and experts in the field. There is no new evidence cited here but it draws on a number of the documents cited in Chapter 1, *Making a fresh start*. These are considered here with regard to their potential impact on supporting recovery.

6.43 *Reducing Harm and Promoting Recovery: A Report on Methadone Treatment for Substance Misuse in Scotland (SACDM, 2007)* consisted of mainly expert opinion with a small amount of evidence from a survey issued to all Scottish drug treatment services. The report stated that methadone maintenance treatment was more cost

effective in terms of harm reduction than any other treatment for opiate dependency, but should be delivered as part of a package of treatment to encourage both harm reduction and enhance recovery. It concluded that methadone treatment in Scotland could be optimised through improving accountability, performance management, information quality, effectiveness, integration and commissioning processes. Research gaps included:

- Current monitoring and evaluation data is sparse.
- Services find it hard to extract data to undertake reviews.
- Outcomes are rarely measured at operational or strategic level.
- More structured performance management systems need to be in place to measure outcomes.

6.44 *The Report of the Stocktake of Alcohol and Drug Action Teams (2007)* reviewed the effectiveness of ADATs in terms of their current performance and future capability to deliver Ministerial policy and priorities. It consisted of working group examinations of the role of ADATs based on semi-structured interviews undertaken with staff members of 22 ADATs.

6.45 The report sets out the key elements of an effective ADAT and concludes with a range of recommendations relating to the future structure and remit of ADATs.

6.46 *Essential Care: A Report on the Approach Required to Maximise Opportunity for Recovery from Problem Substance Use in Scotland (2008)* sought to address the additional non-medical aspects of services required to ensure that people with substance use problems are given every opportunity to recover from their problems.

6.47 The report adopted a recovery ethos as its basis and affirmed the need for service users to access a range of services in order for recovery to take place.

6.48 The report acknowledged a lack of "*objective evidence to support this approach in the field of substance misuse*", but argued that comparisons with the field of mental health (*CSIP common purpose, 2007*) suggest recovery would be meaningful in a substance misuse context. It referenced the Scottish Recovery Network as evidence that recovery is possible and specifically the idea that narratives of recovery can provide hope.

6.49 There is a lack of evidence regarding the extent to which programmes are successful in assisting people with drug misuse problems in achieving a reduction in drug-related harm and promoting recovery. Also, there is a lack of detailed information on staff's expectations of service users – mental health studies argue that where clinicians are more hopeful for recovery for their patients, outcomes are improved.

6.50 The report does not set out what the new outcomes for measuring success should be, nor how services should seek to record these and to whom they are accountable. There is also a lack of evidence around whether some wraparound services have a greater impact than others.

6.51 In addition to these reports, the research team considered a further three sources of evidence regarding the way in which drug services are to be commissioned, delivered and evaluated. These are summarised in brief here with fuller detail in Appendix 1.

Table 6.4 Additional evidence sources relevant to 'Making it Work'

Year	Evidence source	Evidence type	Information gaps
2007	Concordat between the Scottish Government and CoSLA (Scotland)	No up-to-date data. Draft guidance to ADPs on operating in an outcomes environment and to help them identify local priority outcomes related to alcohol and drugs.	High level outcomes related to alcohol and drugs make limited reference to recovery (point 57) and are linked primarily to 'safer and happier families and communities', with the primary focus on reductions in consumption and harms, and increased access to supports.
2008	Report of the Alcohol and Drug Delivery Reform Group (Scotland)	None – based on some workshops but no data presented.	The key question will be how delivery reform will contribute to recovery-oriented systems of care.
2009	A New Framework for Local Partnerships on Alcohol and Drugs (Scotland)	The strategy *'Aims to ensure that all bodies involved in tackling drug and alcohol problems are clear about their responsibilities and their relationships with each other; and to focus on the activity on the identification, pursuit and achievement of agreed, shared outcomes'*.	Not applicable

Findings of the Literature Review

6.52 The findings of the literature review on the categories of *Criminal Justice and Prisons*, *Families, Prevention and Education* and *Treatment and Intervention* are further divided into sub-categories as shown below.

Table 6.5: Findings from the literature review

Subject	Sub-category
Criminal Justice and Prisons	Therapeutic communities
	Co-occurring mental health and substance misuse in prison populations
	Women offenders
	Other forms of coerced treatment
	Recidivism/relapse/re-incarceration
Families	Family involvement in the care of substance misusers
	Parenting skills in treatment
	Predictors of family separation/reunification
	Pregnancy and substance misuse
	Adolescence and substance misuse
Prevention and Education	Deprivation and other societal factors associated with substance misuse
	Characteristics of young people who misuse substances
	Substance misuse and prevention/education strategies within schools and institutions of higher education
	Substance misuse and prevention/education strategies: family interventions and community-based work
Treatment and Intervention	Recovery amongst substance misusers with dual diagnosis
	Substance misusing women
	Treatment and service characteristics
	Black and Minority Ethnic Groups
	Relapse prevention
	Deprivation, housing and employment
	Non-treatment aftercare
	Treatment follow-up and aftercare

6.53 The remainder of this chapter reviews each of these subjects in turn. The purpose of this process is not to provide a critical appraisal of each of the articles reviewed but to:

- identify and explore the extent to which research has been conducted in these areas;
- establish what the key findings are;
- identify any research implications or gaps raised by the authors;

- comment on the relevance of this work to recovery; and
- comment on the relevance of this work to Scotlan.

Criminal Justice and Prisons

Therapeutic Communities (TCs)

6.54 Studies have shown therapeutic communities to be effective in reducing drug use and criminality, although there is some evidence to suggest that this intervention is less successful among women. The effect of therapeutic communities has been shown to reduce over time. However, research has shown that where therapeutic communities are bolstered by an aftercare programme, criminal justice outcomes are improved. In a study by Wexler et al (1999), only 27% of therapeutic community and aftercare programme completers returned to custody (Sacks et al, 2004), compared with around 75% of control group members.

6.55 Research undertaken on TCs in the USA (Hiller, Knight, Saum and Simpson, 2006) has shown that, during treatment, risk taking reduces somewhat and social conformity increases modestly. Hostility also increases over the course of treatment, which may be explained partly through the socialisation process and partly by the fact that a core component of TC programmes is confrontation between peers to challenge anti-social or unacceptable behaviour. There was no relationship between risk taking, social functioning or hostility and 1 and 2 year recidivism rates.

6.56 In terms of treatment outcomes and effectiveness, TCs have been shown to produce good outcomes for recidivism and substance misuse. When combined with aftercare, recidivism is significantly less likely. Where TCs and aftercare programmes are specifically tailored to people with co-occurring mental health and substance misuse problems evidence is more mixed.

6.57 *Relevance to Recovery*: The success of TCs appears to be in preventing recidivism and a return to substance misuse, both of which have implications for the recovery agenda in terms of improved sobriety and citizenship. The evidence that inclusion in an aftercare group on completion of a TC intervention can further support good outcomes chimes with the long term outlook of recovery. This links to the discussion of ROIS (Recovery-Oriented Integrated Systems) in Chapter 3 where the value systems developed in structured therapeutic communities are translated to a community setting.

Co-occurring Mental Health and Substance Misuse in Prison Populations

6.58 A study in the United States showed that integrated dual treatment aftercare for offenders suffering from substance misuse and mental health problems (the majority of inmates) had little effect upon arrests, conviction or jail days when compared with standard aftercare services (Chandler & Spicer, 2006). However, offenders who received integrated dual treatment aftercare were much more likely to attend outpatient appointments than those who did not and were far less likely to require acute hospitalisation or crisis services. Research undertaken on a small sample of people suffering from co-morbidity showed that a community oriented group intervention with citizenship training combined with standard clinical treatment

was effective at reducing alcohol misuse in the experimental group (Rowe et al, 2007).

6.59 In relation to treatment outcomes and effectiveness, the evidence in this area is mixed. Different studies have shown sometimes contradictory results.

6.60 *Relevance to Recovery*: Treatment programmes which include aftercare and thus maintain long-term contact with former offenders who also experience mental health problems may have a positive effect. However, it is clear that more research in this area needs to be done.

Women Offenders

6.61 Between 70% and 80% of female offenders in the USA have a substance misuse problem. Female offenders typically have multiple and complex needs, especially around co-occurring mental health problems and substance misuse, a history of physical and sexual abuse, higher unemployment and lower work skills. Despite this, they have been shown to achieve better outcomes than their male counterparts, both in terms of relapse and recidivism (Pellissier et al, 2003).

6.62 With regards to treatment outcomes and effectiveness, the relatively small body of USA evidence which exists, has shown that gender specific interventions can reap rewards in terms of treatment effectiveness and recovery, specifically case management interventions with follow-up on re-entry into the community, cognitive behavioural therapy (CBT) approaches for women suffering from co-occurring post-traumatic stress disorder (PTSD) and substance misuse problems, using therapeutic rather than punitive sanctions (i.e. treatment rather than imprisonment, building self esteem and utilising the recovery capital associated with motherhood).

6.63 Providing specialist interventions on top of standard treatment is as effective as specialist treatment alone. Specialised post-release services upon re-entry can help to reduce recidivism, as can sustained programmes of aftercare (Sacks, 2004). Remaining clean during the first week after leaving drug treatment was associated with having received longer treatment, a transition plan, avoiding associating with drug users and accessing support for abstinence in the community (Strauss & Falkin, 2001).

6.64 *Relevance to Recovery*: Gender specific interventions which recognise the multiple and complex needs of female offenders are likely to improve treatment effectiveness and outcomes. A recovery framework which recognises a broader, more holistic and longer-term range of outcomes beyond retention, relapse and recidivism may allow for better evaluation of interventions, but there is currently insufficient evidence to support this. Despite the fact that the main body of the research was completed in North America, these findings may be applicable to Scotland. The only women's prison in Scotland, Cornton Vale holds:

> *'Very many prisoners with a high incidence of drug addiction (estimated 98%), mental health problems (estimated 80%) a history of abuse (estimated 75%) and very poor physical health.' (HMP Inspectorate of Prisons, Inspection Report 2005)*

6.65 With this in mind, gender specific interventions which take account of mental health problems, specifically post traumatic stress disorder, may be appropriate for a Scottish setting.

Other Forms of Coerced Treatment

6.66 The evidence around the success of coerced treatment is mixed. Research has primarily been undertaken in North America, where evidence suggests that coercion has an improved effect upon retention in treatment, especially for those offenders who have yet to be sentenced. However, despite longer periods in treatment, abstinence among this group does not necessarily improve (Brochu et al, 2006). Research undertaken by De Leon and Melnick has shown that:

> *'overt compliance with a program based solely on external pressures without high internal motivation is not associated with better outcomes once the client is no longer subject to those external pressures.' (Melnick et al, 2001)*

6.67 However, other studies have shown that legally coerced male prisoners were more likely to be abstinent in the month before follow-up interviews than non-coerced service users. In addition, they were shown to have a lower addiction severity than non-coerced service users (Chandler & Spicer, 2006). A review of the evidence by the National Institute of Drug Abuse (2006) concluded that, '*recovery from drug addiction requires effective treatment, followed by management of the problem over time*' (NIDA, 2006, p1), '*treatment should target factors that are associated with criminal offending*' (p3), and that '*continuity of care is essential for offenders re-entering the community*' (p4).

6.68 Further research compared a group of offenders who were subject to legal sanction for non-compliance with their treatment programme and a group who were on probation but could not be legally sanctioned (Hepburn & Harvey, 2007). The results showed no difference in rates of participation or completion, leading researchers to conclude that the threat of legal sanction did not have any effect. However, the two groups were mainly composed of non-violent offenders with only one or two convictions. It is not clear whether the effect of probation itself would have been sufficient to incentivise participation without legal sanction for a group of relatively low risk offenders. Thus the transferability of these findings to the remainder of the criminal population is questionable.

6.69 Qualitative research undertaken in Scotland (Eley et al, 2005) has offered an insight into the perceptions of offenders with regard to the effect of coercion as well as reasons for attrition and relapse. The study reports on group interviews conducted with 27 men and women who were undertaking either a supervised attendance order (SAO) or a community service order (CSO). The CSO had no drug treatment provision while a short drug and alcohol misuse programme was optional for those on a SAO. Some offenders felt that legally mandated treatment provided a strong incentive for attending treatment and an effective deterrent against breaching conditions, supporting other international evidence around improved rates of retention. Offenders also expressed their views on attrition, explaining that non-attendance was often related to other problems resulting from social exclusion and

chaotic lifestyles, such as debt, ill health and the threat of violence or the fact that medical services often appeared unresponsive to offenders' personal views on methadone maintenance, tending to operate a 'one size fits all' approach. In a broader UK context, Skodbo et al (2007) reported that around half of all offenders who come into contact with the Drug Interventions Programme (DIP) in England shows reductions in offending, by a mean of 79% in the six months following treatment contact.

6.70 Nonetheless, published evidence on the effectiveness of criminal justice diversion schemes remains limited, in spite of the widespread implementation of the DIP in England and Wales. Skodbo and colleagues make the point that further research is required to develop a greater understanding of how individuals move through the criminal justice programme and why DIP appears to work better for some clients than for others.

6.71 In terms of treatment effectiveness, while coercion may improve retention and there is some data to suggest that this has a knock on effect on improvements in sobriety and addiction severity, in general evidence in this area is insufficient, especially in the Scottish context. Review papers note that the methodologies around the research into coerced treatment can be far from robust, with programme retention, lack of proper control groups and self-selecting samples all presenting problems (Fischer, 2003).

6.72 *Relevance to recovery*: It is clear that coercion can provide a strong incentive to participate in treatment, as research in both the USA and Scotland has shown. However, the effect of retention on sobriety among this group is not clear and wider outcomes relating to global health and citizenship are not known. As is shown by Chapter 2 of the present report, there is almost no evidence on criminal justice and recovery. There is a relatively limited literature outside the therapeutic communities prison literature that has focused on recovery among offender populations.

6.73 Additionally, coerced treatment creates ethical dilemmas for many health and social work professionals. The lack of patient autonomy is of concern in and of itself. Furthermore, experience of working with substance misuse service users highlights that recovery can best be achieved when motivation and readiness to change are high (Best et al, 2009). Fischer notes that the drug court model of coerced treatment is problematic in creating a mixed discourse in which the offender exists both as 'criminal' to be punished through discipline and moral correction and as a 'patient' to be cured through therapeutic intervention, creating a dual identity which some academics and practitioners believe to be antithetical and irreconcilable.

Recidivism/Relapse/Re-incarceration

6.74 A significant body of research has been undertaken into client characteristics which predict future recidivism, relapse and re-incarceration among substance misusing offenders. This suggests that older offenders are less likely to be re-incarcerated, as are those who have stable employment. Previous arrests and periods of re-incarceration are positive indicators for further imprisonment (see De Leon et al 2006). However, recovery research has begun to focus on dynamic characteristics, such as motivation and readiness in predicting future patterns of

offending among substance misusing offenders. Individual growth and increased socialisation were found to be higher among non-incarcerated offenders at follow-up (De Leon et al 2006). This is encouraging for recovery in that it implies that an emphasis on improving social skills and boosting self esteem can have a real impact on improved citizenship. Higher motivation and participation in therapeutic community programmes during imprisonment made entry into aftercare more likely, which itself was shown to impact upon lower rates of recidivism and relapse (Melnick et al 2001).

6.75 Litt & Mallon (2003) showed that where offenders have clean sober/support networks around them, they are less likely to relapse. Social support networks, such as AA and NA, are effective in reducing substance use and their effectiveness is in part due to the availability of social networks which discourage drug use. Incorporating social networks into the treatment of offenders has successfully resulted in drops in recidivism and drug use (e.g. Lemieux, 2002).

6.76 In relation to treatment outcomes and effectiveness, while there are some fixed characteristics such as age and previous re-incarceration, which predict recidivism and reincarceration among substance misusing offenders, there are others which can be changed through treatment. Improved prosocial skills and the establishment of social networks can reduce the likelihood of reoffending.

6.77 *Relevance to Recovery*: Encouraging social skills and channelling substance misusing former offenders towards networks of social support can reduce reoffending and thus promote better citizenship.

Families

Family Involvement in the Care of Substance Misusers

6.78 Involvement of the family in treatment programmes for substance misusers in the USA has been shown to have positive effects. Landau et al (2004) found that where a family member or friend called outpatient drug treatment clinics to ask for help in getting loved ones into treatment, substance misusers could be engaged in the process relatively quickly; the more severe the family member perceived their loved one's problem to be, the more motivated they were to make contact.

6.79 Chassin et al (2009) found that where families were involved in the treatment of serious male juvenile offenders, outcomes around smoking cessation and non-drug offending were improved. A study of schizophrenia patients found that the presence of substance misuse predicted an irregular pattern of attendance; the support of family members predicted a more regular attendance. However, where patients experienced co-morbid schizophrenia and substance misuse, and had the involvement of family members in treatment, such involvement was able to mitigate somewhat for the negative effects of substance misuse on service attendance. (Fischer et al, 2008). A further study of individuals with co-morbid mental health problems and substance misuse found that family involvement, both in terms of economic assistance and informal caregiving was associated with a reduction in substance misuse (Clark, 2001).

6.80 Network therapy, where the families of substance misusers participate with the individual in group therapy has been shown to be effective in helping the addict break down denial and rationalisation of their problem. Furthermore, family involvement can assist the addict in identifying addictive cues and support them in their avoidance of these (Galanter & Brook, 2001). This work has been continued in the UK with the development of Social Behaviour Network Therapy (Copello et al, 2005) which evaluated positively in the UK Alcohol Treatment Trial. A small study in the USA found that a skills training programme for parents of adolescent substance misusers improved parental coping skills, communication within the family and had some effect on reducing the drug use of the adolescent child (McGillicuddy et al, 2001).

6.81 With regards to treatment outcomes and effectiveness, the inclusion of family in treatment, has been shown to improve treatment attendance among individuals with co-occurring schizophrenia and substance misuse.

6.82 *Relevance to Recovery*: It is not clear what the mediators are between family involvement in treatment and improved outcomes. They may lie in the increased social and emotional support or, as Fischer suggests, in the provision of practical support, such as transport to treatment for substance misusers living in rural areas, thereby enabling greater exposure to treatment. Such contributions to recovery cannot be underestimated; however, there is currently insufficient evidence, especially in the Scottish context, to make strong assertions about the role of the family in recovery.

Parenting Skills in Treatment

6.83 There are several studies from the USA that comment on the inclusion of a focus on families in treatment for parents with substance abuse problems. Research in Massachusetts found that retention in treatment for substance abusing mothers was improved where parenting skills were included in the treatment programme when compared to both non-gender specific treatment and gender specific treatment (McCornish et al, 2003). Grella et al (2009) found that where treatment programmes included a parenting element, reunification between substance abusing mothers and children who had been removed to foster care was more likely. Additionally, research in the North-Western USA has shown that including parenting skills in treatment can reduce the risk of male children of substance misusers from themselves developing addiction problems (Haggerty et al, 2008). There is also evidence that substance abusing parents who have custody of their children have somewhat more severe addictions than parents without custody of their children. It may be the case that in a group which uses substances as a coping mechanism, the stresses of parenting act as a push factor into greater substance misuse (Lewis & Petry, 2005).

6.84 In terms of treatment outcomes and effectiveness, family oriented treatment programmes can improve retention and sobriety outcomes for substance abusing mothers; further research conducted on a larger scale will be necessary.

6.85 *Relevance to Recovery*: Improving parenting skills may help substance misusing parents to stay in treatment for longer, thus providing the best possible

chance at achieving recovery. Furthermore, such interventions have been shown to improve parenting attitudes and beliefs, potentially reducing the stresses associated with childcare and the related triggers back to relapse. It is clear that there is further work to be done in this area, especially with regard to larger sized trials with adequate control groups.

Predictors of Family Separation/Reunification

6.86 A recent study compared women who had been separated from their children and women whose children were still living with them using data from a large, federally funded, longitudinal study of women with co-morbid mental health and substance misuse disorders and histories of violence. Women who had had at least one child removed from their care were more likely to have a greater number of children, to have been homeless, to have been in juvenile detention or jail, to have experienced greater lifetime or current exposure to stressful and interpersonally abusive events, to have prostituted themselves for money or goods, to have been physically attacked by a stranger and to have experienced unwanted sexual contact than those women who had not had a child removed (Nicholson et al, 2006).

6.87 Evidence around family reunification has been gathered by Grella et al (2009) in California on children taken into care as a result of maternal substance misuse. The research found that mothers with poorer psychiatric and employment status were less likely to be reunited with their children; children under two were also less likely to be reunited with their parents. Reunification was more likely where mothers remained in treatment for 90 days or more and where treatment programmes provided a high-level of family related or education/employment related services. Brook and McDonald (2007) assessed provision of services to families where the child has been removed due to parental alcohol and drug disorders. It was found that multidisciplinary, intensive services that address a range of needs from a single point of contact for families had less successful outcomes than standard services; reunification took longer among the experimental group and re-entry of the children into care services was more common.

6.88 *Relevance to Recovery*: The multiple and complex needs of women with substance misuse problems impacts on their ability to care for their children and may result in their children being removed from their care. Recognition that this group is exceptionally vulnerable and may need a range of supports including housing, mental health treatment and parenting classes could prevent this outcome.

Pregnancy and Substance Misuse

6.89 Evidence from the USA indicates that pregnant women utilise substance misuse treatment services in a different way to non-pregnant women. Daley et al (1998) found that pregnant women used treatment services more regularly, were more likely to be admitted to methadone maintenance programmes and residential programmes and were also more likely to be re-admitted to detoxification. Further research has shown that there was no difference in retention in residential or outpatient treatment among a small sample of cocaine-dependent pregnant women (Comfort and Kaltenbach, 1999). However, this same study showed that a significantly higher proportion of the pregnant women in the residential programme

maintained abstinence throughout the course of treatment than those in the outpatient programme.

6.90 With regards to treatment outcomes and effectiveness, while greater treatment service utilisation may not necessarily produce better outcomes, there is a correlation between increased use of services and improved abstinence, especially if women participate in residential programmes.

6.91 *Relevance to Recovery*: The increased use of treatment services and the use of more intensive treatments among pregnant women may suggest that pregnancy can be a turning point (Finkelstein & Piedade, 1993) due to the desire to protect the best interests and health of the unborn child.

Adolescence and Substance Misuse

6.92 Adolescents follow broadly the same recovery path as adults, but experience things at a different level of intensity and over different timescales. The fact that teens are also undergoing the individuation/separation tasks associated with maturing complicates recovery processes; they are more likely to behave in a hostile manner towards people who they view as authority figures (i.e. therapists) and reject the idea that they are dependent. The desire to become independent and autonomous will probably also lead them to believe that they can resolve the addiction without assistance, which means that accepting their addiction takes much longer. Despite this, adolescents can and do make progress (Blumberg, 2005).

6.93 Supportive parents are key to adolescents becoming abstinent and developing as autonomous individuals. Further research with male serious juvenile offenders (Chassin et al, 2009) has shown that family involvement in substance use treatment reduces cigarette smoking and criminal offending behaviours. Furthermore, a study of resilience in individuals (DuMont et al, 2005) who had been abused either physically or sexually as children found that those who had lived in a stable environment (either with two parents or in a long care placement) were more likely to be resilient in adolescence (the definition of resilience included the absence of a diagnosis for alcohol and drug abuse).

6.94 Evidence around the participation of adolescents in 12-Step programmes (Chi et al, 2009) shows that maintaining attendance at 12-Step programmes after one year made alcohol abstinence at three years more likely. 12-Step attendance at 3 years increased the likelihood of *both* alcohol and drug abstinence. Social support was found to be a factor in the success of attendance at 12-Step programmes and abstinence, possibly because such programmes encourage abstinent friendship groups.

6.95 Therapeutic Communities have been shown to be an effective way to improve psychological and substance misuse outcomes among adolescent probationers (Morral et al, 2004).

6.96 In relation to treatment outcomes and effectiveness, therapists can be more effective by understanding that teen hostility stems mainly from the conflict between needing to accept the powerlessness and need for help associated with addiction,

and the development of individual personality and autonomy. Patience and understanding are likely to be required. Framing the recovery process as the individuation/separation process can assist adolescents (Blumberg, 2005); enabling adolescents to experience abstract ideas may also assist their engagement with the recovery process (Gillis & Simpson, 1994).

6.97 *Relevance to Recovery*: Adolescents are able to achieve long-term sobriety and may be more resilient than their adult peers, since their personality is not fully formed and they can adapt more readily to recovery ideas. However, the conflict between accepting addiction and separation/individuation tasks can lead to great hostility within families. Outcomes are much improved for teens if they have the support of their families. Recovery can enable adolescents to develop high levels of empathy for others and perhaps this can assist in the healing of wounds within families as well as improving citizenship.

Prevention and Education

6.98 *The Road to Recovery* states that problem drug use is strongly linked to socio-economic disadvantage. Besides deprivation, there are other routes into drug misuse such as enjoyment, escapism and peer support. These involve a degree of free choice and can therefore be addressed at the individual level through prevention and education strategies. The focus of such strategies is to impact on the attitudes, beliefs and behaviours associated with drug use.

6.99 Therefore this section will provide evidence drawn from UK good practice guidance documents regarding the role of deprivation and other societal factors in drug misuse and examine evidence regarding effective interventions aimed at younger people within school and higher education settings as well as community based approaches. Interventions relating to housing and employment with a focus on recovery are examined later in this chapter.

Deprivation and Other Societal Factors Associated with Substance Misuse

6.100 The relationships between deprivation, poverty, widening inequalities and drug use are well-documented in the literature. The report *Drugs and Poverty: A Literature Review* (2007) published by the Scottish Drugs Forum (SDF), discusses these links in detail, although this was not a systematic review. The report states that such relationships often involve *'psychological discomfort, fragile family bonds, low job opportunities and community resources'*.

6.101 The authors highlighted that the Scottish Parliament Social Inclusion, Housing and Voluntary Sector Committee (SIHVSC) officially recognised that: *'deprived communities with poor housing, poor amenities and high levels of unemployment'* experienced the most serious levels of substance misuse (SDF 2007) and that problem drug use '…*is inextricably linked with other extreme forms of social exclusion, notably homelessness, persistent offending and street prostitution'* (SIHVSC 2000, cited in SDF 2007).

6.102 The authors of the SDF report examined the evidence regarding the causation of problem drug use. They highlighted the conclusion of the Advisory Committee on

the Misuse of Drugs (1998) that there is a strong statistical correlation between problem drug use and deprivation, although the committee did state that such relationships are not straightforward.

6.103 The fact that deprivation does not directly cause addiction is another important point that is discussed. It is emphasised that the causes of deprivation are experienced by people on an individual basis, and so these negative social factors merely tend to raise the likelihood of someone developing a substance misuse problem, by weakening what can often be referred to as protective factors, and by strengthening risk factors (Young 2002, as cited in SDF 2007).

6.104 According to the authors of the SDF report, a number of British studies have found that *'for a significant proportion of clients, social disadvantage and exclusion were major issues prior to the onset of a drug habit'* (Buchanan 2004, as cited in SDF 2007).

6.105 Buchanan (2004) says that deprivation does not mean that people will definitely go on to misuse drugs, but simply that problem drug users are more likely to have had problem childhoods, including negative experiences such as growing up in care and exclusion from school. The authors of the SDF report raised questions regarding whether such relationships are being '*followed through into policy and practice*' and state they '*should be taken into account*' and in turn *'form the development of assessment and intervention strategies'* (SDF 2007).

6.106 Consequently, it is vital to not only understand and address societal factors in terms of the subject of promoting recovery from drug misuse, but also with regards to implementing suitable prevention strategies within Scottish society. Tackling important issues such as poor housing and employment will therefore have a positive impact at both of these levels.

6.107 It is stated in *The Road to Recovery* (Chapter 2, p12) that '*not all people in deprived areas will develop a drug problem…*' and therefore it is important to review other factors, which lead people to misuse drugs, for example: mental health problems (discussed later in this chapter), recreational use and peer networks. Although the research evidence to support the efficacy of drug prevention initiatives (other than those discussed above) is lacking, there are examples of peer support programmes across Scotland, which are independently evaluated by bodies, such as the Lloyds TSB Foundation for Scotland and the Big Lottery Fund.

Characteristics of Young People Who Misuse Substances

6.108 According to the report, *Joining Forces, Drugs: Guidance for Police Working with Schools and Colleges* (2006), the majority of young people of school age do not misuse drugs, drink alcohol or smoke tobacco. It is well-documented that cannabis is the most common illegal drug currently used by those aged 18 years and under; although its use amongst young people is presently in decline. The document highlights the fact that the number of youngsters '*who report being offered illegal drugs has risen, and the age at which young people first use them is falling*'.

6.109 There are a number of risk factors and protective factors that have been identified for young people with regards to problematic drug use (Table 6.6). It should be noted that the more risk factors a young person experiences, the greater the likelihood of them developing a drug problem. However, it is important to state that these risk factors are not predictors of drug use amongst young people, as not everyone who experiences such risk factors, will end up misusing substances.

Table 6.6: Risk and Protective Factors

Risk Factors	Protective Factors
Chaotic home environment	Strong family bonds
Parents who misuse drugs or suffer from mental illness	Experiences of strong parental monitoring with clear family rules
Behavioural disorders	Family involvement in the lives of children
Lack of parental nurturing	Successful school experiences
Inappropriate and/or aggressive classroom behaviour	Strong bonds with local community
School failure	A caring relationship with at least one adult
Poor coping skills	
Low commitment to school	
Friendship with deviant peers	
Low socio-economic status	
Early age of first drug use	
Being labelled as a drug misuser	

Table adapted from *Joining Forces, Drugs: Guidance for Police Working with Schools and Colleges* (2006, p16)

6.110 The publication, *Drugs: Guidance for Further Education Institutions* (2004), states that young people who may be vulnerable to drug use are those who:

> *'are looked after or who have recently left care; who truant or have been excluded from schools; have special educational needs; mental health problems; are in contact with the criminal justice system; live with drug misusing parents/carers; and are homeless or involved in prostitution.'*

6.111 The authors stress the importance of identifying vulnerable young people in order to ensure they receive appropriate support. In turn, the implementation of such a strategy may be an effective method of reducing substance misuse in this sub-population. However, this may be a further evidence gap and a potential area for research within Scotland.

Substance Misuse and Prevention/Education Strategies within Schools and Institutions of Higher Education

6.112 This section addresses drug use prevention among young people, and the effectiveness of different strategies. Research highlighted in the report, *Joining Forces, Drugs: Guidance for Police Working with Schools and Colleges* (2006), only demonstrates that specific drug education models can obtain *'modest reductions'* in cannabis, alcohol and tobacco consumption, as well as delay the onset of their use.

6.113 Additionally, *'there are indications that drug education has a role in reducing the risks associated with drug use',* as well as the amount of drugs used, and can assist people to stop misusing substances (*Joining Forces*, 2006). However, these statements are not necessarily supported by other reports.

6.114 McGrath et al (2006) completed a systemic review for NICE (National Institute for Clinical Excellence), examining the effective components of drug prevention programmes in schools. The authors state that:

> *'since past research on drug prevention programmes has shown mixed results in terms of efficacy, no quality criteria or guidelines have been developed for schools, policy makers and prevention workers, to help choose which programmes should be delivered to young people.'*

6.115 Therefore, the purpose of this study was to systematically review three types of drug prevention studies: meta-analyses; primary studies examining mediating variables of drug use; and studies examining effective characteristics of programmes.

6.116 The research found there was:

> *'a lack of UK evaluation studies, which means it is difficult to deliver evidence-based prevention programmes in this country, since diversity in environmental factors among countries (e.g. cultural, societal and developmental factors) can affect effectiveness and/or implementation.'*

6.117 This comment was pertinent, because the majority of the publications reviewed were based on primary research conducted in the USA, and so it is vital to carry out research within Scotland. The conclusions drawn by the authors, were that findings were generally consistent with those of Canning et al (2004), stating that there '*is a lack of methodologically sound evidence*' making it difficult to determine which drug prevention strategies work effectively among young people. In addition, it is suggested that there is '*inappropriateness in terms of a 'one size fits all' approach to drug prevention*', and so research is required to determine '*what types of interventions are effective in particular populations*'.

6.118 The publication, *Pathways to Problems* (2006), provides a further detailed review of the current evidence base, and the authors summarise the findings by stating that:

'The extensive published research on school-based preventative initiatives makes disappointing reading. While many of the evaluations were poorly designed, those that were conducted to an acceptable standard found that even carefully designed, resourced and implemented programmes resulted in, at best, small short-lived delays in the use of tobacco, alcohol or other drugs by pupils. Indeed, many studies showed no effect at all and some programmes were found to be counter-productive.'

6.119 The researchers further conclude by saying:

'the evaluations of current practice in England and Scotland indicate wide variations in standards, with many schools using traditional, information-based methods that are least likely to be effective. Despite this, drugs education policy in the UK continues to be based on the assumption that drugs education is effective, investing large amounts of staff and pupil time and resources in such activity.'

6.120 The Blueprint Drug Education Programme was a major research project conducted between 2004 and to 2005 in England (Institute of Social Marketing, University of Stirling, 2007). It was developed as a partnership between three Government departments: the Home Office, the Department for Education and Skills (DfES) and the Department of Health (DH). The study aim was '*to examine the effectiveness of a multi-component approach to drug education*' and '*it was the first attempt to design, deliver and evaluate a multi-component programme on such a large scale in England*', with the view to informing '*the development of future drug educatio*n'. The project involved classroom-based lessons within schools, alongside '*working with parents, the media, Local Education Authorities (LEAs) and the community*', as well as policy work.

6.121 The findings of the Blueprint Drug Education Programme cannot be summarised concisely here. The multi-component approach has led to various studies examining specific aspects of the project, but none have attempted to assess the overall impact of the programme and its effectiveness, especially in relation to prevention of substance misuse.

6.122 The document, *Drugs: Guidance for Further Education Institutions* (2004), states that '*research indicates that young people enjoy and learn from drug education delivered by their peers*' and that '*many young people request an input from an ex-user who has had experience of drug misuse*'. In terms of the latter, it is very important to ensure '*the input is suitable*', as well as '*relevant and presented well*'. Additionally, the authors highlight the necessity of ensuring that monitoring and evaluation processes are being built into drug education programmes, so quality and effectiveness can be readily assessed. The methods utilised would have to be carefully devised in order to make sure programmes are being reviewed consistently. However, this may be a useful process to implement within Scotland, regardless of whether substance misuse education is being delivered in schools, colleges or universities.

6.123 The authors of the document, *Alcohol and Drug Prevention in Colleges and Universities: A Review of the Literature* (Polymerou, 2007), state that '*little is known about the harm that alcohol and/or drugs cause, among further education college and university students in the UK*', as there are no recent studies that examine this subject. The findings of this literature review are consistent with those highlighted in other reports, as previously discussed in this chapter.

Substance Misuse and Prevention/Education Strategies: Family Interventions and Community-Based Work

6.124 The *Pathways to Problems* (2006) publication briefly discusses drug prevention in settings other than schools. The authors evaluated a systemic review published in 2006, which assessed 17 Randomised Controlled Trials (RCTs) that had been conducted over the ten-year period prior to the start of the study. The researchers who conducted the review categorised the interventions into four types: multi-component community studies; family intervention studies; education and skills training; and brief interventions. They conclude that '*no definite evidence for their effectiveness was obtained*' and state that '*further high-quality trials were needed to explore interventions that appear to have a 'potential benefit*'. In addition, they state that:

> *'there was insufficient evidence that the five multi-component community studies which were considered, had any advantage over the school-based programmes with which they were compared. Neither of the education and skills training interventions had any effect, nor did the majority of the eight family interventions.'*

Treatment and Intervention

Recovery Amongst Substance Misusers with Dual Diagnosis

6.125 A significant percentage of substance misusers suffer from co-morbid psychiatric disorders. These diagnoses not only have serious consequences for the individual, but also for their family and community. Murray and Lopez (1996) reported that in 1990 '*mental health disorders accounted for 5 of the 10 most burdensome diseases in the world*' (Tiet and Mausbach, 2007).

6.126 The prevalence rates for substance-related disorders among patients with mental health problems are between 33% and 66% for those diagnosed with lifetime schizophrenia disorder (Alterman et al, 1982; Barbee et al, 1989; Mueser et al, 1992; Tiet & Mausbach, 2007). Additionally, Reiger et al (1990) reported that over 56% of persons with any lifetime bipolar disorder have been diagnosed with a substance abuse problem, as identified through the large Epidemiologic Catchment Area (ECA) study in the USA. Grant et al (2004) found that around 60% of clients seeking treatment for drug misuse suffer from a co-morbid mood disorder, with 42% diagnosed with an anxiety disorder. It is estimated that between 55% and 99% of women with dual diagnosis have experienced some form of trauma (Jennings, 1997; Miller, 1994; Najavits, Weiss and Liese, 1996).

6.127 The joint report of the Scottish Advisory Committee on Drug Misuse and the Scottish Advisory Committee on Alcohol Misuse (2003), *Mind the Gaps*, cited data from the Scottish Drug Misuse Database (SDMD) showing that between April 2001 and March 2002, over 40% of people who sought treatment for drug problems (3,236 from a recorded population of 10,798) reported mental health as one of the issues which led them to treatment. This figure is especially concerning given the fact that these data '*may not necessarily be complete or consistent across Scotland*' (Scottish Advisory Committee on Drug Misuse and Scottish Advisory Committee on Alcohol Misuse, 2003, p23) and other British studies possibly suggest an even greater prevalence (see Chapter 3). In the light of such statistics, it is clear that the diagnosis and the efficacious treatment of psychiatric conditions, within substance misusing populations, needs to be a focus within a Scottish recovery agenda.

6.128 The evidence around the success of treatment for those with dual diagnosis is rather poor, as discussed in the review by Tiet & Mausbach (2007). The authors evaluated 59 studies of which 36 were randomised trials and reported that only a limited number had investigated specific options for different categories of co-morbidity. In addition, it was noted that:

> *'treatments had not been replicated and consistently showed clear advantages over comparison conditions for both substance-related and other psychiatric outcomes'.*

6.129 In summary, the authors concluded that it was not possible to identify *'specific treatment options that were simultaneously efficacious for psychiatric disorders and forms of substance misuse.'*

6.130 However, Tiet & Mausbach (2007) did find that:

- *'Tricyclic antidepressants reduced depressive symptoms among depressive substance-abusing individuals'.*
- *'Seeking safety and relapse prevention may reduce Post Traumatic Stress Disorder (PTSD) and substance-related problems among women'.*
- *'Cognitive-behavioural therapy + motivational interviewing may benefit individuals with substance-related disorder and schizophrenia'.*

6.131 A further study, this time conducted by Sacks et al (2008), reviewed the effectiveness of utilising a modified Therapeutic Community (TC) approach for people with co-occurring disorders in an enhanced outpatient programme. It was reported that these clients had significantly better outcomes compared with the control group who received a traditional substance abuse day treatment programme that included standard elements of individual and group therapy and counselling focussed on relapse prevention. The positive outcomes were on measures of psychiatric severity and on housing stability (substance misuse, crime and employment outcomes all remained unaffected). However, as the authors state, this study only provides '*modest support*' in terms of this intervention, as the findings must be treated with caution. Seventy-nine percent of the participants involved were of African-American origin, and improvements may not translate to a Scottish population.

6.132 Another study investigated the characteristics of 50 clients suffering from '*severe and enduring mental illness*' in high support community residences in the Dublin North East Mental Health Service (as discussed by Kavanagh & Lavelle, 2008). The study concluded that positive outcomes were achieved following:

> *'active rehabilitation interventions, but there remained a cohort of patients whose needs could not be met in a supported community rehabilitation residential programme'.*

6.133 The authors highlighted the importance of ensuring that '*a range of rehabilitation services, from inpatient to supported community placements*', are provided to meet the needs of such patients.

6.134 Min et al (2007) reviewed the effectiveness of *The Friends Connection* peer support programme as a potentially useful intervention for clients with three year re-hospitalisation patterns and showed that participants experienced longer community tenure. This provides some evidence that such peer support programmes may facilitate recovery for people with dual diagnosis. In addition, Timko et al (2003) found that Mutual Aid groups may be beneficial for helping dual diagnosis clients to successfully overcome their '*daily living and social skills deficits*', as this treatment option can provide '*long-term continuity of care for psychosocial and cognitive difficulties as well as an addiction*'.

6.135 Timko et al (2005) found that to facilitate the integration of psychiatric and substance abuse treatment, it is vital to emphasise cross-system and interdisciplinary teamwork, as well as long-term staff commitment to improve the quality of care. They recommend the Comprehensive Continuous Integrated System of Care (CCISC) to enhance treatment capacity for dually disordered individuals based on eight principles (e.g. dual diagnosis is an expectation, not an exception). The authors mention that a toolkit is currently being produced to help systems and agencies implement evidence-based practices for adults with severe mental illness and co-occurring substance use disorders and they indicate that these tools if used by treatment planners and managers should be helpful in creating truly integrated treatment.

6.136 Elliott and Masters (2009), examining mental health inequalities in Scotland, reported that a major cause is poverty. The authors also indicated that current policy needs to be set out more clearly, especially around the role of mental health nursing as this group of health professionals should have:

> *'a key role to play in helping to shape existing physical and mental health services so that these services are more accessible and helpful for those who use them.'*

6.137 The authors concluded that gathering further evidence on the subject would provide a better understanding of the health needs of different populations, as very little is known about what types of approaches might be best suited to different social groups.

6.138 *Relevance to Recovery*: To promote recovery in patients with dual diagnosis, further research is urgently required. As highlighted by Tiet & Mausbach (2007), it is also important that more methodologically rigorous trials are carried out, including better controlled and randomised studies that make the distinction between primary and secondary psychiatric disorders or symptoms. Other recommendations to researchers, from these authors, to improve the evidence include:

> *'to investigate the interaction between medication and substance use needs; ensure sufficient sample sizes and maintain high study completion rates; include multiple and long-term outcome measures and measures of mediating mechanisms; report effect sizes; include results for trial drop-outs within analyses; differentiate between treatment effects and the effects of the total amount of services patients receive; examine cultural influences on treatment processes and outcomes; investigate clinician and programme factors that are related to patient outcomes; and lastly evaluate treatment guidelines.'*

Substance Misusing Women

6.139 Metsch et al (2002) assessed treatment outcomes in a cohort of 4,236 women in Florida and found that treatment completers were less likely to be receiving welfare benefits at follow-up, and that residential rehabilitation was also associated with lower welfare benefit payments. Predictors of reduced welfare benefit payments were being younger, better educated, being married and having less criminal justice involvement. In assessing outcomes among pregnant women and drug using mothers, Connors et al (2006) found significant improvements in substance use, employment, offending, mental health, parenting and risk, with longer treatment stays associated with better outcomes. Toussiant et al (2007) also showed positive treatment outcomes for women who had been the victims of trauma in a study of 170 women engaged in a structured treatment programme.

6.140 In a study of women with comorbid substance use and mental health problems, Morrissey et al (2005) reported positive outcomes with better outcomes associated with the provision of greater levels of 'integrated' counselling. Greenfield et al (2007) conducted a review of 280 published articles since 1990 and reported that women were less likely to access drug treatment than men, but that, once in treatment, retention and outcomes were no different, although there were gender specific outcome predictors.

6.141 With regards to research implications and gaps, there is a need to develop and test effective treatments for specific subgroups such as older women with substance use disorders, as well as those with co-occurring substance use and psychiatric disorders such as eating disorders. Additional research on effectiveness and cost-effectiveness of gender-specific versus standard treatments, as well as identification of the characteristics of women and men who can benefit from mixed-gender versus single-gender treatments, would advance the field. Further research is also required to identify the longer-term effects of integrated counselling for women with co-occurring disorders and trauma histories.

Treatment and Service Characteristics

6.142 Scott et al (2005b) studied recovery stages in 1,326 adult substance users showing movement, over the three years of the study, between (i) community or incarcerated use, (ii) treatment and (iii) being in the community not using. This provided evidence for a staged model of change and recovery. In a second developmental study, Claus et al (1999) reported on the recovery processes of 7,092 clients accessing treatment in St Louis and found that recovery change could be evidenced and that the change process takes places via multiple mechanisms. Based on the Californian outcome data referred to in Chapter 3, Hser et al (2007) found that, compared with individuals still addicted after 30 years, individuals in recovery were less likely to have spouses who used drugs and more likely to have more non-drug using social support, greater self-efficacy and lower psychological distress.

6.143 In a 5-year treatment outcome study in the USA, Satre et al (2004) found that older adults were more likely to achieve total abstinence from substances at follow-up, and that abstinence was also made more likely by having no close friends who were substance users and longer retention in treatment. In focusing more on the details of the treatment process, Simpson et al (2000) looked at one year outcomes and found that treatment process measures – treatment engagement and satisfaction, and motivation for treatment – were predictors of reduced substance use and offending, and improved family relationships at one year after treatment initiation.

6.144 In a meta-analysis of psychosocial interventions across a range of substances, based on a total treatment sample of 2,340, Dutra et al (2008) described an overall moderate positive effect across all participant groups. The authors commented that while psychosocial interventions had least effect for polydrug users, contingency contracting (the use of incentives as a form of behaviour modification, also known as 'shaping') was found to be the intervention with the strongest resulting effects.

6.145 However, there is a strong meta-therapeutic effect. De Leon et al (2000) found that more experienced professional staff increased client retention and improved client functioning in a residential TC setting. Similarly, in a study of cultural congruence in therapeutic relationships, Longshore et al (1999) reported greater treatment engagement and higher motivation with culturally congruent therapists and clients.

6.146 In terms of research implications and gaps, although there is evidence around the impact of specific interventions, an increased focus on the structure and context of treatment is gaining greater prominence (see Chapter 3). This is particularly the case with regards to therapeutic engagement and working relationships, as well as the cultural milieu of treatment services.

6.147 *Relevance to Recovery*: There is empirical support, albeit from the USA, for a staged approach to recovery, including a recovery process for those engaged in the criminal justice system. There is also evidence that long-term recovery may well be

linked to social networks and the development of recovery capital identified as positive recovery self-efficacy.

6.148 In terms of relevance to Scotland, the research has been conducted in the USA, and so caution is needed about applicability to a Scottish context. Consequently, piloting of such interventions, alongside appropriate evaluation, may be beneficial.

Black and Minority Ethnic (BME) Groups

6.149 Surveillance and surveys suggest that drug use in the UK is more prevalent amongst those from white ethnic groups. While this may be the case, there are likely to be substantial numbers of minority ethnic drug users, with geographical variations and differences in the types of drugs being used.

6.150 *Drug Misuse Statistics Scotland 2009* (Information Services Division, 2010) reports that in 2008/09 there were 99 non-white people presenting to drug services, as new clients. This represents 0.9% of all presentations in that year where ethnic group was recorded[19]. Scottish population figures provided by the General Register Office for Scotland (GROS, 2008) confirm that there are 101,677 non-white people living in Scotland, accounting for 2% of the population.

6.151 In order to ascertain whether there is an under-representation of non-white problem drug users, at drug services in Scotland, there are three issues to consider:

1) Are the prevalence and trends of drug use similar between white and non-white groups?
2) What might be the barriers to non-white problem drug users accessing drug services?
3) What are the mechanisms for monitoring and reporting on ethnicity across drug services in Scotland?

Prevalence and Trends

6.152 Glasgow has the highest proportion of residents from non-white groups in Scotland (GROS, 2001). In a study into drug issues affecting Chinese, Indian and Pakistani people living in Glasgow, Ross et al (2004) concluded that drug use was present and increasing across the three ethnic groups, but that prevalence rates were still reported at lower levels than for the general population. This finding was echoed in a review of drug use in Black and Minority Ethnic groups in England (Fountain et al, 2003), which found drug use to be increasing, and in some communities as prevalent as it is within the white population. In a synopsis of five studies carried out on issues surrounding drug use and drug services amongst different ethnic populations in England, Fountain (2009) concluded that the drugs used and the relative popularity of each among the various black and minority ethnic samples, are not substantially different to those of the whole population.

[19] 11342 cases. There were an additional 613 cases where ethnic group was not recorded.

Barriers to Accessing Services

6.153 The document, *Integrated Care for Drug Users: Principles and Practice* (Rome et al, 2002), states that minority ethnic drug users have traditionally been reluctant to access existing services and that service providers must be more sensitive to the needs of minority ethnic groups. This involves providing materials and support in languages other than English, providing services to address the drug of use (e.g. not just opiates), and working with families with different cultural backgrounds and values. Fountain points out that:

> *'it does not follow that black and minority ethnic drug users can simply slot into existing drug services because they face a series of barriers to accessing these services';*

and that the responsiveness of drug services is a long-term process at a strategic level, rather than an '*add on*' to existing services.

6.154 In a Scottish study reviewing vulnerability and access to care for South Asian Sikh and Muslim patients with life limiting illnesses, the authors (Worth et al, 2009) identified a number of themes more evident in the South Asian population than the general population. Although the study focussed on palliative care and dying, there are some factors which should be considered by drug service providers. These include:

- Illness and suffering are viewed as God's will and a test of faith.
- Despair and anger are seen as spiritual deficits and therefore emotional problems are difficult to acknowledge openly.
- Institutional or overt personal racism sometimes apparent in patients' and carers' interactions with services.
- Some patients and families were reluctant to seek help from services they perceive as racist, or because they had poor experiences of services or were concerned about criticism from their own community.
- Inadequate professional training in diversity and concern about causing offence through lack of cultural understanding.
- Some staff awareness of the needs of Sikh and Muslim patients but uncertainties about how to adapt usual care to a different cultural context.
- Professionals uncertain about accurate, complete and effective communication when patients or family members act as interpreters.

6.155 A national scoping study of drug prevention and drug service delivery to minority ethnic communities, conducted in 6 DAT areas in England in 2000/2001 (Sheikh et al, 2001), showed that '*symbols of accessibility*' were important. This means explicitly demonstrating that minority ethnic groups are welcome to utilise services, for example by providing posters, leaflets, cultural-specific newspapers and magazines (Sangster, 2002).

6.156 However, it was emphasised this was only one aspect of what is required to help services become more culturally sensitive, and thereby enhance accessibility for ethnic minority groups. Other recommendations include a shift away from delivering services for opiate injectors to the development of services with a more

holistic, therapeutic and social focus and also an emphasis on the importance of 'cultural competence' to mainstream services.

Mechanisms for Monitoring and Reporting

6.157 The data currently collected by ISD Scotland through the Scottish Morbidity Reporting system (SMR25 notification forms), allows for monitoring of the number of new individuals from black and minority ethnic groups accessing drug services in Scotland each year. It also allows for measuring the proportion of people in any one health board or local authority area accessing services. It is anticipated that the introduction of follow-up reporting to the Scottish Drug Misuse Database will build a picture of the total number of people from black and minority ethnic groups currently engaged with drug services (as opposed to only recording new presentations).

Implications for Research and Practice

6.158 In 2003, Fountain and colleagues produced the guidance document '*Black and Minority Ethnic Communities in England: A Review of the Literature on Drug Use and Related Service Provision*', which was published by the National Treatment Agency for substance misuse (NTA, 2003). Although primarily focussed on England, it provides evidence and guidance which is applicable to services planning and provision more generally.

6.159 The *Tackling Drugs, Changing Lives: Diversity Manual* (Home Office, 2006) provides further guidance on the operational aspects of service design and delivery for minority groups, including black and minority ethnic groups.

6.160 More recently the UK Drug Policy Commission has commissioned a number of evidence reviews aimed at understanding the needs and challenges of drug problems for different minority groups. These are as follows:

- Prevalence and patterns of (illicit) drug use within different ethnic groups.
- Drug prevention and information provision for different ethnic communities.
- The interaction and impact of drug markets and drug-related enforcement activity on different ethnic groups.
- The prevalence of drug use, access to and need for services, and the impact of enforcement on the LGBT community.
- The prevalence of drug use, access to and need for services, and any impact of enforcement on disabled people.

6.161 These reviews have a UK-wide remit and are due to be completed in early 2010.

Relapse Prevention

6.162 It is important to ensure that individuals maintain the changes they have achieved after leaving treatment. Dennis et al (2002), in Chicago, showed that the average time for the participants to reach a year of abstinence following discharge is eight years (with three to four episodes of treatment in between). According to Brown et al (2002), the six month period following discharge is the crucial period that

determines whether or not relapse will occur. Sixty to 80% of relapse occurs during this period (Marlatt & Gordon, 1985). Recovery is a longitudinal process which involves building a different lifestyle by learning to cope with issues such as pressure of relapse, acquiring new attitudes, skills and relationships (Hser et al, 2007).

6.163 A substantial body of research has been carried out to determine the interventions effective in preventing relapse. Relapse prevention is a cognitive behavioural intervention involving assessing the possible factors linked to increased risk of relapse and improving the self-efficacy of the individuals (Brown et al, 2002). Brown et al (2002), when studying substance misusers in Canada, showed that relapse prevention and 12-step both achieved positive outcomes by significantly reducing the percentage of substance use, but that for the relapse prevention arm of the study, this self-efficacy effect lasted only for the duration of the aftercare programme (10 weeks).

6.164 A few studies conducted in the USA comparing day drug abuse treatment versus residential treatment report similar outcomes for both groups (Greenwood et al, 2001). Greenwood et al (2001) compared the relapse outcomes of day programmes and residential treatment at six, twelve, and eighteen month follow-ups, providing evidence for the effectiveness of day drug abuse treatment at the six month follow-up. However, there was no significant difference between the two types at the twelve and eighteen month follow-ups.

6.165 Greenwood et al (2001) also re-examined Guydish et al's (1998; 1999) data to identify baseline predictors of relapse at twelve and eighteen months for both day and residential treatment. The predictors positively correlated with relapse included: being employed part-time or full-time in the three year period prior to relapse; having a history of injecting drugs; and number of sexual partners. The correlation between employment and relapse was thought to be 'related to work related difficulties and having to compromise their recovery needs to meet survival needs' (Greenwood et al, 2001). The risk of relapse remains alive even for those who have been in remission for years (Drake et al, 2005). According to current research, key strategies to prevent relapse include learning self-control, avoiding situations that have relapse potential, reducing exposure to substances and coping with cravings (Brownell et al, 1986; Witkievitz et al, 2004; cited in Drake et al, 2005).

6.166 Relapse factors among substance misusers with mental illnesses are similar to the general substance misusing population: negative emotions; social stress; interpersonal problems; lack of involvement in satisfying habits; and attempts to escape from personal experiences. However, unique relapse factors to this group include the fluctuating nature of long-term mental disorders, lack of normal developmental experiences, social victimisation, lack of necessary treatment resources and biological factors (Drake et al, 2005). Thus, when providing relapse prevention for substance misusers with mental illnesses, it is important to consider cognitive and social dysfunctions and the need for long-term mental health treatment as well as assistance with housing and employment.

6.167 Further evidence regarding relapse among substance users with psychiatric disorders comes from a 6-year Norwegian follow-up study carried out in 2006 by Landheim et al. The results showed that those who relapsed were younger, less

often married at the start and follow-up, and had higher rates of major depression and agoraphobia at baseline. Within the relapsers, those with major depression at baseline had higher mental distress compared with those without the disorder at the follow-up.

6.168 In terms of treatment outcomes and effectiveness, in relation to relapse prevention aftercare programmes, both CBT-based and 12-step strategies appeared to offer beneficial outcomes. However, the changes did not persist past the treatment phase. Similarly, in addition to drug abuse day-treatment being more cost effective, is has been shown to be more effective in relapse prevention during the initial 6 months of aftercare. Thus this method can be used to assist high-risk clients to prevent relapse in the initial months of aftercare.

6.169 *Relevance to Recovery*: A significant and independent contribution to severity of drug use has been shown to be confidence and self-efficacy in high-risk situations. Therefore, using aftercare interventions, such as relapse prevention and 12-steps, which aim to build self-efficacy and confidence in clients are likely to be an important step towards recovery. Further, major depression and agoraphobia have been shown to be predictors of long-term relapse, suggesting that assessing and treating these disorders early on may reduce long-term relapse.

6.170 Although none of this research is Scottish based, relapse prevention research shows the importance of bridging the gap to post-treatment, as well as the need for ongoing support to be available to those exiting treatment.

Deprivation, Housing and Employment

6.171 *The Road to Recovery* (p12) describes a 'clear link' between deprivation and drug misuse. It identifies housing, employment, training and education to be part of a joined-up approach to promoting recovery.

6.172 There is some evidence to indicate that post-treatment housing can have a significant effect on potential for lapse and relapse. Progress towards a drug free life can be impaired if substance misusers exit treatment and return to '*an environment that promotes crime and drug use*' (Jason et al, 2008, citing evidence from Polcin et al, 2004). A study of group homes found that the type of accommodation provided could impact on criminal justice and substance abuse outcomes. Specifically, residents living in larger group homes have greater opportunities for social contact with recovering addicts and were found to have improved criminal justice and substance abuse outcomes compared with their counterparts living in smaller homes (Jason et al, 2008). This has been well understood within some treatment programmes in Scotland which facilitate new tenancies and a break from the old life for many substance users exiting treatment.

6.173 Research into relapse among homeless populations found that there was not a significant difference between the length of time which it took for homeless and non-homeless people to resume their drug use following treatment. However, where homeless people were offered a booster to normal treatment their rate of return to substance misuse was lower. These boosters consisted of stabilisation programmes which were:

'voluntary, short-term, transitional facilities offering temporary treatment support and residence for 2 to 6 weeks while longer term residential placement options are considered.' (Kertesz et al, 2003)

6.174 Employment has been recognised as of great importance in helping to reinforce and sustain the recovery process (McIntosh et al cite Westermeyer 1989; Platt, 1995; Klee et al, 2002; Biernacki, 1986; Luchansky et al, 2000; McIntosh and McKeganey, 2001; Cebulla et al, 2004). The inclusion, esteem and opportunities for social contact which are associated with employment help to prevent lapse and relapse (McIntosh et al, 2008). The impact of employment within the DORIS cohort is discussed in Chapter 4.

6.175 This has significant implications for future treatment provision, which should look to provide employment related assistance as standard if substance misusers are to maintain recovery and realise the opportunity to make an economic contribution.

Non-Treatment Aftercare

6.176 One of the few comparisons of mutual aid groups was conducted by Brooks and Penn (2003) in which 224 dually diagnosed substance users were randomly assigned to 12-step or to SMART Recovery. Benefits from 12-step included reduced drinking and greater social interactions, while SMART (Self Management And Recovery Training) participation led to improved health and employment, with the authors recommending a wider range of outcome indicators and longer follow-ups in future research.

6.177 In a study of 12-step focusing on injecting drug users, Crape et al (2002) found no differences at one-year outcomes between those with and without a 12-step sponsor, but that ongoing engagement with community organisations was strongly linked to sustained abstinence. However, being a sponsor did confer significant benefits in terms of long-term abstinence. In a study linking residential treatment to ongoing support in Oxford Houses, Jason et al (2007) found that those who stayed longer in the ongoing provision had better substance use outcomes than the comparison aftercare group. Crits-Cristoph et al (2003), in a study of 12-step engagement in cocaine users found that involvement in Cocaine Anonymous (CA) was a partial predictor of reductions in cocaine use, but recommended a need for greater investigation of the mechanisms of change.

6.178 In terms of continuity of care, Kelly et al (2006) assessed mutual aid participation 1, 2 and 3 years after alcohol treatment and found that mutual aid participation was associated with greater abstinence and less drinking, irrespective of religious belief, gender or previous mutual aid experience. There are nonetheless obstacles to 12-step engagement and Laudet (2003) reported that motivation and perceived need for help were barriers to attendance and suggested that there is a strong need for clinicians to provide information and education about 12-step groups. As mentioned in Chapter 3, there is also evidence that intensive referral by professionals to 12-step groups (Timko & deBenedetti, 2007) led to both greater AA attendance and better substance use outcomes 6 months and one year later.

6.179 However, there is also evidence for peer support not linked to 12-step. Boisvert et al (2008) reviewed a peer support community focused on self-determination and found significant reductions in relapse risk. In a review of self-help organisations, Humphreys et al (2004) concluded that involvement in self-help groups was associated with reduced substance use, improved psychological functioning and reduced economic burden on the healthcare system.

6.180 *Relevance to Recovery*: While there is evidence of added value of engagement in mutual aid after formal treatment, there remain barriers for both clients and professionals that need to be addressed. There is a very strong evidence base in favour of mutual aid, although much of this evidence has been developed around Alcoholics Anonymous.

6.181 In terms of relevance to Scotland, according to the NA website[20] there are 97 NA meetings held in Scotland each week, and based on the CA website[21] there are 28 CA meetings held in Scotland each week. Based on the SMART Recovery website[22] there are 12 SMART Recovery meetings held in Scotland, although these are primarily held in the North of Scotland and this does not include many of the groups run through specialist treatment services. Additionally, there are 242 listed meetings of AA in Glasgow alone. Thus, there is considerable availability of structured mutual aid and this does not include unaffiliated community groups or professionally run aftercare supports.

Treatment Follow-up and Aftercare

6.182 Jason et al (2007) assessed community aftercare for 150 individuals leaving residential treatment by randomly assigning participants to recovery housing or standard aftercare and found that the recovery home group had better outcomes in terms of substance use, employment and offending, with a greater effect for those retained for longer in the recovery homes.

6.183 One particular aspect of aftercare, Recovery Management Check-ups (RMC, see Chapter 2), was assessed by Dennis et al (2003) based on quarterly check-ups. Those provided with recovery check-ups returned to treatment faster if they relapsed but had lower rates of relapse. In a further study of the RMC approach, Scott et al (2004) conducted two-year follow-ups and provided further support for effective re-engagement and positive outcomes using the recovery check-up model. More recently, Scott and colleagues (2009) completed a quarterly study of functioning over two years using the recovery check-up model in which participants were contacted quarterly. Benefits were seen in lower levels of substance dependence, more days of abstinence and higher levels of functioning. Rush et al (2008) have also demonstrated the effectiveness of the RMC model in a study of clients with a dual diagnosis in Canada.

6.184 Hubbard et al (2007) assessed the effects of phone calls after discharge from residential treatment and showed improved compliance and outcomes, but the

[20] Narcotics Anonymous website, http://www.ukna.org/meetings/ [accessed 7 January 2010]
[21] Cocaine Anonymous website, http://www.cascotland.org.uk/meetings.htm [accessed 7 January 2010]
[22] SMART Recovery website, http://www.smartrecovery.co.uk/ [accessed 7 January 2010]

results did not reach statistical significance. A similar approach, of assertive continuing care (ACC) was assessed by Godley and colleagues (2007) for adolescents, with assertive aftercare associated with better treatment engagement and higher abstinence rates than the standard aftercare package.

6.185 *Relevance to Recovery*: There is strong support for effective continuity of care to aftercare services, with a growing evidence base for the recovery-management check-up model, effective in both reducing relapse risk and in treatment re-engagement of those who do lapse. It is essential that links to aftercare involve an assertive linkage model and the RMC approach also provides a potential role for individuals in recovery as the cohort who do the recovery check-ups.

6.186 Aftercare has a particularly limited evidence base in the UK, yet it is imperative in order to sustain the gains made in treatment, that effective linkage to community and professional supports are provided and that the aftercare provision is evaluated and monitored locally and nationally.

Overview

6.187 The international literature suggests considerable support for the underlying principles of recovery – in particular the importance of continuity of care beyond acute treatment, the importance of providing community-based supports, and the important lifestyle changes associated with safe housing and meaningful opportunities for training and employment. The evidence base around recovery also links to the GIRFEC and CAPSM work by emphasising the reciprocal benefits of a family focus on improved recovery outcomes and for improving the wellbeing for the children and partners of substance using parents. There is also a growing evidence base around what works in criminal justice settings, including prisons, that emphasises the potential role of peer influence (in therapeutic communities) and the importance of ongoing support and care beyond the influence of the treatment setting. The principles of recovery – continuity of personalised care, focus on families and communities and the preservation and support for hope (even in the most complex cases of co-morbid mental health problems and recidivistic offending) are evident across the wide array of studies reviewed.

CHAPTER 7 – CONSULTATION WITH KEY EXPERTS

Summary: Perceptions of the Expert Group Consulted in this Research

1. Amongst the evidence experts consulted in this research, there was an overall consensus that a clear strategy is needed for developing an evidence base that will both support and test key aspects of the national drugs strategy.
2. Although there was optimism about the evolution of standard data collecting in Scotland, there was a recognition that it would take considerable time for this to yield the type of research information needed.
3. Almost all of the experts agreed that the state of drugs research in Scotland was poor and particularly limited in areas such as clinical research and treatment effectiveness work.
4. Nonetheless, there were seen to be examples of innovation and good practice, but that these frequently lacked the rigorous evaluation and dissemination to justify replication elsewhere.
5. Key areas identified as needing further research were around long-term outcomes, in terms of individual recovery, the effectiveness of alternative medications to methadone (buprenorphine and suboxone), the effectiveness of community and residential rehabilitation, and technology transfer work on effective implementation of research.
6. A number of potential funding bodies were considered and a range of strategies for re-invigorating drug research in Scotland including a research consortium and the 'importation' of dedicated research expertise.

7.1 The aim of the project was to conduct the documentary analysis and literature review components of the work as the first phase of the review process and then to 'test' this with a range of key experts in the drugs field who we would task with identifying additional sources of research and information, key evidence gaps and with providing feedback on the first phase of the analysis. The group of key experts consisted of three main groups:

1. Members of the research advisory group for this review;
2. Members of the National Drugs Evidence Group (NDEG) in Scotland, and
3. Other key subject experts.

7.2 There was a generic list of questions for all of the interviewees with specific questions addressing each person's area of expert knowledge added as appropriate. The broad questions asked of all interviewees are included in Table 7.1.

Table 7.1: Questions for Key Experts

Background
What is your role?
What was your role in the development of *The Road to Recovery*?
What do you see as the 'evidence chain' that it is based on?
The Evidence Base in Scotland
What do you think are the key assumptions about recovery that need to be tested?
What do you think we need to know about the application of the evidence base to Scotland in terms of: treatment effectiveness; long-term outcomes; recovery literature?
What are the completed studies that we need to know about that have taken place in Scotland that are relevant to the review?
What are the other sources of data (monitoring, evaluation, audit, 'grey literature') that we should be accessing?
Are there examples of good practice of recovery in Scotland that have been evaluated in some way?
Purpose of the Review
What would you like to see coming out of the review?
Have the Scottish Government already identified key evidence gaps?
In terms of developing this agenda, who are likely to be the key collaborators [e.g. National Treatment Agency (NTA), National Institute of Health Clinical Excellence (NIHCE), etc]
Have you any other comments?

7.3 Having completed the documentary analysis, a draft of the report was circulated to the members of the research advisory group, the National Drugs Evidence Group and to the other key experts where possible. Members of these groups were contacted to request their participation in a structured interview which was conducted either face-to-face or by telephone if that was not possible. Prior to commencing the interviews, the interviewee was informed of the procedure for confidentiality and accuracy. This involved:

- Assurance that none of the individuals would be quoted by name.
- If direct quotations were used, the interviewee would be given the opportunity to review these for accuracy, although the quotations would not be attributed.

7.4 At the start of each interview, the interviewees were asked if they were clear about the process and were happy with the method of recording. None objected to this.

7.5 The information presented below is an overview of the responses obtained in the interviews. A total of 16 interviews were conducted between 23 November and 22 December 2009. Two of those approached did not feel that they had enough specialist knowledge to contribute and so declined to participate.

The Evidence Base in Scotland

7.6 A number of the respondents expressed their dismay at the scarcity of the existing research evidence base in Scotland.

7.7 Several of the respondents felt that there was a strong pool of addiction researchers and academics who would generally be willing to work together, but the limited nature of research funding and the lack of programme research or clear strategic research aims have hindered the development of potential research collaborations across Scotland.

7.8 Another respondent felt that, while there was considerable innovative practice in Scotland, this was not reflected in a commensurate evidence base, particularly since the demise of the Scottish Executive's Effective Interventions Unit (EIU). This respondent also contrasted the situation with the alcohol evidence base which was perceived to be more established and where there was a greater academic consensus.

7.9 Existing research work that was identified included:

- Follow-up study of survival and long-term injecting cessation (Edinburgh included as part of a multi-site study)
- Pharmacy supplementary prescribing study (Aberdeen)
- Training in psychosocial interventions for pharmacists (6 centres)
- Study of supervision arrangements for methadone (Aberdeen)
- Scottish Government funded evaluations of the pilot community rehabilitation projects initially funded by the outgoing Liberal/Labour administration, including LEAP (Edinburgh).
- Additional recently completed research includes assessments of arrest referral and drug courts, the evaluation of mandatory drug testing of arrestees, and evaluations of homeless interventions and a psycho-stimulant clinic (all funded by the Scottish Government)
- Initiation of the drug-related deaths database and the development of Scottish Morbidity Record 25 (SMR 25a&b) to enable better data linkage

7.10 There were also suggestions that there was a lot that could be learned from the English model of developing the national database for treatment (National Drug Treatment Monitoring System, NDTMS) and using this as the basis of treatment outcome research, as reported in the Lancet article (Marsden et al, 2009) in which positive treatment outcomes were reported – in the first six months of treatment, more than one-third of heroin users and more than half of crack cocaine users reported that they were abstinent from illicit drugs[23].

[23] The follow-up options available on the Scottish Drug Misuse Database (SDMD) Follow-up Reporting System will provide information on clients throughout their care episode with data collected

7.11 There was considerable discussion about the DORIS project and whether it had satisfied all of our knowledge needs around treatment effectiveness in Scotland (see Chapter 4 for an overview). Concerns raised included the length of follow-ups within a recovery focus, and whether it provided a sufficient platform for testing recovery-oriented approaches such as the community rehabilitation model implemented by Glasgow Addiction Services and in the Lothians and Edinburgh Abstinence Programme (LEAP). This led some respondents to suggest that there still remained the need for cohort studies with longer-term follow-up windows.

7.12 Another cohort that could yield further follow-up research would be work done around a cohort of methadone service users in Glasgow although it was acknowledged that not as much of that had been published as would have been desirable to date. It was also suggested that the NDTMS data (including the Treatment Outcome Profile) provided a huge research resource that could be made available for a wide-range of policy and research projects, and that similar potential existed for outcomes research on a treatment seeking population identified through SMR25, the treatment forms used in the Scottish Drug Misuse Database (SDMD). Thus, one of the ongoing NTA projects in England, identified by a key informant is the generation of a 'data warehouse' for offending and treatment data that can start to answer questions about long-term changes in behaviour in treatment seeking populations.

7.13 There was also the perception that there have been important pieces of work in policy in Scotland including the *Essential Care* report reviewed in Chapter 6, which was seen as having set the scene for *The Road to Recovery*. There was also the positive perception that the introduction of follow-up reporting in the Scottish Drug Misuse Database and the development of a drug death database would significantly improve the monitoring function, although it was acknowledged that it will take some time before these are ready for analysis that can inform policy. However, the aim is that this will begin to yield data on outcomes and recovery, and will also provide additional information about the numbers of children living with drug users entering treatment.

What are the Research Gaps Pertinent to *The Road to Recovery*?

7.14 The key domains of *The Road to Recovery* that needed to be examined include clearer definitions of what is meant by recovery, and some methods for reconciling population level indicators with the assumption that recovery is an individual process. It was also suggested that we have little evidence around what configuration of services are needed to enable the diversity of individual expressions in recovery journeys. Another consideration that needed to be examined was that of 'citizenship' and how this links to broader political goals of social inclusion, and what the need for treatment is if natural recovery is to be considered seriously. Another respondent summarised the key research challenges that are salient for the implementation of *The Road to Recovery* as:

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at initial assessment, 12 week follow-up and then annually for retained clients or at discharge for those exiting treatment. This will include measures of substance use, social functioning and child care and a process assessment of the interventions received.

- The challenge of translating the existing recovery evidence base to drug users and to the Scottish context.
- Within the Scottish drug using population, applying these principles equivalently across specific groups such as stimulant and opiate users, younger users and minority groups.
- Testing the assumption that there are lots of problem drug users who have the potential for recovery, who are not currently achieving it, and who can be assisted by a new approach, and whether treatment services can have a positive impact on the recovery trajectory of individuals.
- Addressing co-morbid drinking and switching from problematic heroin to alcohol use.
- Assessing the effectiveness of medication assisted recovery as a parallel path to abstinence-oriented recovery.
- Assessing staffing and cultural issues at play in developing a recovery model, and being clear about what the outcomes framework is for services.
- Identifying the mechanisms by which recovery research questions could be tested in pilot formats and approaches.

7.15 As a footnote, one of the respondents observed that the Scottish Government (and Executive) had produced a huge amount of literature but it was questionable how much of this had shaped or even influenced policy or practice. Another respondent felt that there was a problem about sharing the existing information and that much of the good work that had been done around evaluation of services and projects had not been widely disseminated, to either policy makers or practitioners, in Scotland.

7.16 There was also a key question around whether the introduction of a recovery culture in Scottish treatment services would fulfil the broader social change issues around social and welfare issues of effective reintegration and active participation in society and the economy.

7.17 Another respondent felt that there needed to be considerable focus on the shift required in the professional culture and the resulting implications for workforce training and development within a recovery model. There is the presumption that evaluating such change will require not only implementation issues but also should incorporate the time window required to embed a recovery culture effectively.

Areas for Further Research and Investigation

7.18 Key areas for research in Scotland that were identified included:

- Research into heroin injecting and the learning from the Randomised Injectable Opioid Treatment Trial (RIOTT) of injectable heroin in England
- Assessing the options available as substitute medications including studies comparing methadone with buprenorphine and suboxone
- More longitudinal studies
- More research on older drug users, including late onset drug problems to assess whether we really have an ‘ageing’ drug using population
- Work to improve the adequacy of the current prevalence estimations
- More research examining the effectiveness of residential rehabilitation treatment,

including rapid detoxification
- Primary care as a research setting was seen as important, both in terms of the optimal models for the delivery of shared care treatment and of an evidence base that included GP settings as part of a treatment outcome model

7.19. However, one respondent felt that Scotland was still struggling with the basic data questions about what is being delivered and to whom, and there was a perception that services were still struggling to cope with the data demands placed on them. It was also recognised that there are issues around the timeliness of data and that the Scottish Drug Misuse Database (SDMD) does not necessarily capture all that is needed.

7.20 However, the data go back to 1998 (although the recording system has changed since then) and there is the possibility of follow-up work and data linkage. A follow-up recording system has been introduced to track clients' progress through treatment. This will permit an assessment of the relationship between interventions received in treatment and changes in substance use, housing and employment, legal situation and family circumstances. Baseline data is collected at the time of treatment engagement with follow-up data collected at 3 months and then on an annual basis for those remaining in treatment. Information will also be collected at the point of transfer to another service or discharge for those who exit the treatment system.

7.21 Further data linkage is planned to take place between information in the SDMD and all the other alcohol / drug related data sources available within ISD. ISD is currently working with key stakeholders including Alcohol and Drug Partnerships, drug and alcohol services and the Scottish Government to inform the analytical strategy which will underpin this linkage and analytical work.

7.22 These developments should allow some of the basic treatment monitoring that is collected in England using NDTMS to be assessed in Scotland, and also to enable wider research questions to evolve from the basic data management processes. It will also enable basic mapping of 'treatment journeys' as people move through different treatment providers and episodes of care in their overall recovery journey. Mapping this information will be essential to our understanding of recovery pathways.

7.23 Nonetheless, these improvements did not mean that there were not fairly basic research questions to address about why Scotland has such a high drug use prevalence rate when compared with the rest of the UK and how this relates to both culture and deprivation factors. While there was a perception that Scotland did not need to replicate all the evidence-development work done elsewhere, there was a recognition that much greater attention needed to be devoted to questions of knowledge transfer and the application of principles of research from other settings.

7.24 There are also key questions to be answered about what organisational factors promote recovery and also to consider national survey work that might start to address research questions around 'natural recovery' in populations who do not utilise formal treatment services. Another interviewee observed that the local issues of good workers and services are often ignored where those very personal and local

issues may be at the heart of what will promote recovery. There is a major concern that recovery is such a localised issue, contingent on peer effects and the contextual and historical impact of communities, that an evidence base will look much looser and be based on broad principles of recovery rather than specific interventions to be delivered in a particular order.

Potential Areas for Funding and Coordinating Research

7.25 Participants were also asked about potential funding sources for research, and representatives from independent funding bodies in Scotland were included in those participating in the research. Among the potential funding sources suggested were:

- Medical Research Council (MRC)
- National Institute of Health Research (NIHR)
- Chief Scientist's Office (CSO) in the Scottish Government
- Health Service Research Committee (HSRC)
- European Union (EU)
- Wellcome Trust
- Robertson Trust
- Joseph Rowntree Foundation
- Lloyds TSB Foundation
- Cross-Governmental Research Programme on Drugs (CRGPD).

7.26 Outline summaries of the priorities and funding mechanisms of each of these organisations are set out in Appendix 2.

7.27 In England, the Cross-Government Research Programme on Drugs (CGRPD) has been set up to improve the development and use of the evidence base by better coordinating drugs research across Government. The core research priorities for CGRPD are to:

- Strengthen understanding of aetiology, prevalence, incidence and patterns of drug use
- To improve the understanding of drug use in core populations, including young people, offenders, BME groups and families
- To review measures of drug-related harm
- To develop understanding of treatment, prevention and other demand-based indicators
- To improve the understanding of drugs markets and how to tackle them
- To strengthen understanding of public perceptions and confidence.

7.28 The CGRPD will not commission research and the funding of research will remain the responsibility of individual departments but it will oversee progress to meeting the overall targets of the English drug strategy. However, it is essential that Scottish Government and NDEG develop a relationship with this group in terms of shared opportunities for research and joint mechanisms for assessing the effectiveness of study outcomes and implementation. As one of the objectives of CGRPD is to develop and communicate a shared vision for future drug research, there are potential benefits to communicating with this group around the

development of the evidence framework emerging from this review.

7.29 Around funding issues, one respondent felt that the key was to get proper funding for strong research designs with suitable follow-ups as we have been too reliant on outcome studies that are increasingly out of date and are based on insufficient numbers and inadequate follow-up periods. One concern expressed was that people are in such a rush to adopt recovery principles that they are doing so without the proper evaluation mechanisms being in place.

7.30 Finally, participants were asked to identify examples of good practice in recovery in Scotland with the most commonly cited example being LEAP (Lothians and Edinburgh Abstinence Programme), but even there some respondents suggested that the evaluation did not go far enough and that it was not a service that would meet all needs. One respondent answered in terms of the examples of good practice from the mental health field, including the social model from New Zealand, and examples from the Scottish Recovery Network.

Aspirations for the Review

7.31 At the most basic level, it was hoped that the review would produce:

> *'recommendations that are evidence-based, do-able, practical, pragmatic, manageable, useful for broad populations and acceptable to patients.'*

7.32 More specific suggestions were for a graded summary of the evidence base, better awareness of the research going on in Scotland, and commitment to research influencing policy.

7.33 It was suggested that setting a clear research agenda which could be agreed with other funding bodies was important and that the review suggested some broad themes of developmental research along with some specific study areas. Another respondent suggested that the identification of significant research gaps should be based in part on an assessment of what is already working in Scotland that was beyond the scope of the current review, and the existing building blocks that could reasonably be built upon.

7.34 One respondent suggested both specific actions – such as improved assessment, better integration between treatment services, more partnership working – as well as broader aspirations such as recovery focussed movement, the development of recovery champions, greater involvement for carers and families and changes in the philosophy and delivery of specialist treatment.

Identifying the Way Forward

7.35 One of the respondents suggested that a Scottish Drugs Research Forum would be a useful mechanism for pinpointing and prioritising areas for investigation and to highlight the areas of strength and weakness in the evidence base. This could be linked to the National Drugs Evidence Group (NDEG) or be a sub-group of NDEG whose key aims would be:

- Developing an ongoing dialogue with practitioners and recovery groups about knowledge and evidence gaps.
- Linking that to international research evidence where appropriate and making links with research collaborators and funding bodies in the UK and internationally.
- Working with policy makers and service providers around generating an implementation framework for practice and for disseminating key evidence messages.

7.36 The same respondent also suggested developing a network of key organisations from inside the drugs field (NHS and Health Scotland, SDF, NTA, the Alcohol and Drug Partnerships [ADPs]) and organisations with a broader remit (NICE, SIGN, MRC, Royal Colleges, Education for Scotland, ACPOS, children and young people's services and social work) to commit to joint work. A second respondent made a similar suggestion around a research consortium to generate an infra-structure that would be similar to equivalent work in the mental health field.

7.37 However, one of the participants felt that this did not go far enough and that what was required was a structural change:

> *'what is needed is research leadership and infra-structure. Pay for a big name professor to come to Scotland for five years and do for drug research what people like Sir Philip Cohen has done for cancer research. Set up a research facility which can provide a lead nationally and internationally. We have the worst drug death rate in the world as well as one of the highest prevalence rates. We need to be getting serious about research and that means spending a lot of money.'*

CHAPTER 8: REVIEW AND CONCLUSIONS

Summary: Overview of Recommended Developments

The review confirms the need for a more strategic, programmatic approach to developing the drugs recovery evidence base in Scotland. To ensure that the implementation of *The Road to Recovery* is informed by the best possible evidence, the authors suggest the following actions:

1. Develop a drug research forum linked to the National Drug Evidence Group to focus on three key areas of research activity - recovery-specific; treatment and interventions; and prevention and public policy.
2. Develop a key focus on the transitions to abstinence and the continuity of care in the course of recovery journeys, with a significant focus on community and mutual aid groups.
3. Improve the understanding of treatment delivery and the 'technology transfer' of evidence within a framework of generating an improved evidence-based culture.
4. Improve our understanding of the benefits and costs of long-term prescribing and how to generate recovery communities within maintenance treatment services.
5. Prioritise research and subsequently negotiate with key bodies around programmatic research funding support both within Scotland and as a participant in international recovery and addiction work.
6. Develop appropriate collaborations and funding opportunities outside the addictions silo looking to the key areas of recovery gain to evaluate and fund recovery-oriented activities.

Where Are We Now?

8.1 This review has found that while there is a growing body of research evidence in the USA around recovery from addiction, there are limitations in translating the learning from this evidence into a Scottish context. Scotland has a core group of experienced and skilled researchers who have used a wide-range of research techniques and methodologies to produce some innovative work around epidemiology, treatment effectiveness and treatment innovation. However, the lack of research programme support has meant that this work appears patchy in the evidence base, whilst it is also apparent that it has been the result of the endeavours of a small group of individuals, rather than a growing body of experts, particularly those tied to the recovery agenda or to treatment and prevention providers. Research and evaluation of recovery in Scottish contexts has also fallen behind the innovations that have taken place in recovery practice in Scotland (eg the innovations observed in recovery communities). Therefore, in relation to the evidence reviewed and in particular the USA literature, the limitations observed were:

- much of the research is dated;
- much of it is qualitative and based on samples of unknown representativeness, with only limited outcome and epidemiological evidence to substantiate some of these preliminary recommendations;
- a significant proportion of the available evidence has focused on alcohol using populations;

- there is a limited evidence base about the role of long-term treatments on recovery outcomes;
- the USA client groups and treatment response systems are significantly different to those in the UK, which should be taken into account when making comparisons or interpreting findings.

8.2 As a result, the limitations described above are confounded by a modest local evidence base in Scotland of 'what works' in recovery, which has resulted in a reliance on evidence from England and the USA on the effectiveness of particular types of treatment, for instance substitution treatment, detoxification and rehabilitation. This is particularly relevant in a country where expert consensus would suggest that there is an evidence gap around local research and evaluation.

8.3 Nonetheless, there is a strong and flourishing recovery movement in mental health in Scotland coordinated through the Scottish Recovery Network[24] (and a linked research group in the UK called the Recovery Research Network), that has provided evidence for policy and practice in this area. However, there is a limited evidence base using cohort and outcome research methods that use standardised instruments as identified in the Joint Position paper (Care Services Improvement Partnership et al, 2008) so the drug recovery movement, in Scotland and elsewhere, must develop its own empirical support and infrastructure to enable not only recovery research, but a range of approaches to evaluate, audit and review recovery processes. There are sufficient examples of both academic research (in the form of outcomes studies such as DORIS and the Glasgow methadone cohort research programme) and pilots of innovative practice (such as the work on naloxone done in Glasgow and Lanarkshire and the pharmacy work in Aberdeen) to suggest that there are the foundations for developing a drugs research framework for Scotland. There has been some strong work done around epidemiology and mortality (e.g. Copland et al, 2004), but this has not resulted in sufficiently programmatic research. The major benefit that could result from a forum involved in collaborating with NDEG to implement a Drugs Research Framework is that good quality work could be produced on a planned and systematic basis with appropriate follow-ups and the capacity to develop clear themes of evidence and knowledge gathering focused on recovery that are built around a solid core of standard monitoring data. This could enable research teams to develop the skills and expertise and build research units that can represent Scotland internationally and participate in major international research collaborations on recovery and the drugs evidence base more generally. One of the key legacies from *The Road to Recovery* should be a commitment to ensuring that this omission is addressed.

Measuring Recovery and Treatment Effectiveness

8.4 There are also clear limitations in terms of what we know about the Scottish context. Both of the more recent UK outcomes studies – DTORS in England and DORIS in Scotland – have had short outcome windows, which means they can say relatively little about the long-term recovery transitions that individuals experience. They also only offer insights into the outcomes of those individuals who have sought formal treatment. As raised in the consultation phase of this research, key experts in

[24] Scottish Recovery Network website, http://www.scottishrecovery.net [accessed 5th March 2010]

the drugs evidence field also highlighted questions around the types of information that are being measured – the focus is frequently on health, offending and risk, while a transition to studies of long-term recovery would involve much greater assessment of lived experiences and quality of life, active participation in families and communities and active engagement in meaningful activities. Any recovery-focused outcome studies would need to examine a much longer time window – to account for the putative 5 to 7 years that is typically associated with recovery from opiate use. They would also need to look much more at the effects of recovery oriented services (such as community and residential rehabilitation, and engagement in mutual aid and other community groups), which would require a move away from the current focus on acute care (methadone treatment, detoxification, etc) as the 'index treatment' that is assessed in most of the UK and international outcome studies conducted to date. Thus, cohort or outcome studies would potentially cover longer time windows, use different measures of outcomes and would begin with different trigger points for inclusion as the starting point of a recovery journey.

8.5 Thus, any research agenda and evidence framework emanating from this review needs to account for two tracks – those that focus specifically on recovery as a long-term and community-based activity and those that relate to the effectiveness of acute treatment, where there is a much greater international evidence base but the same questions persist about translating research findings to the Scottish context. This reflects the findings in Chapter 7, where key experts in the drugs evidence field identified major gaps in knowledge around types of substitution treatment and their relative effectiveness (methadone versus buprenorphine), as well as studies of the effectiveness of detox regimes, of rehabilitation and more generic questions around patterns and prevalence of drug use in particular groups, such as older adults, and around particular substances for example psycho-stimulants. However, there is a broader research agenda that links to both recovery and to treatment effectiveness that is around the comparability of different fields.

8.6 There is also a much smaller evidence base around criminal justice populations and long-term recovery and about the recovery pathways of adolescents. There is also a limited research evidence base about the differences in recovery pathways by gender, ethnicity or substance use profile and a lack of sufficient treatment effectiveness knowledge mediated by these demographic variables. Finally, there is an extremely limited addictions clinical research capability in Scotland particularly around the 'what works' agenda, with no adequate evidence base around technology transfer and implementation questions. This is key in terms of both being able to translate international rules and principles (such as those produced by NICE and SIGN), but also about developing in clinicians and other practitioners the basics of audit and evaluation as the core building blocks of an evidence-based culture for helping services.

8.7 However, *The Road to Recovery* does not only deal with adult problem drug users and their issues of addiction and dependence. The development of a balanced evidence base requires the production of an overall knowledge map that allows comparisons to be made between measures of recovery and relevant outcome measures in the other key strands of public policy – drug education, wider prevention, supply reduction, criminal justice and disease prevention/harm reduction. An increased focus on developing a common evaluation language for interventions –

perhaps measured in terms of effect sizes, outcomes and health/cost effectiveness – would enable policy makers to decide on the relative merits and impact of different interventions in different domains covered by *The Road to Recovery*.

Using Monitoring Data as a Core Building Block in Research

8.8 As mentioned in Chapter 7, the initiation of follow-up data obtained through the enhanced Scottish Drugs Misuse Database (SDMD) Follow-up Reporting System has the potential to significantly improve the breadth and quality of monitoring information on the medium and long-term outcomes for clients accessing drug treatment services in Scotland. Data will be collected at the following points throughout a clients' care episode – initial assessment; 12 week follow-up; annual follow-up; discharge from service; and transfer from service. These multiple data points for long-term treatment clients will provide data that will constitute the basic building blocks in mapping both treatment populations and of change processes at a population level.

8.9 This will provide not only a basic performance management framework, but will also enable the comparative effectiveness of different modalities of treatment to be assessed alongside overall treatment impact on substance use and on wider outcomes around social functioning, including the links to family involvement. This will enable basic mapping of the overall treatment population as well as the tracking of:

- variability by age and gender
- applicability to diverse populations (including BME groups)
- relevance for young people and primary offenders
- links to the mental health recovery movement and the issues that arise in dually diagnosed populations
- geographic variations, including rural groups.

8.10 ISD Scotland are undertaking a programme of quality and development work over the next 3 to 4 years to improve this process and to enable consultation about what people would like to see from the data collected. It is hoped that, by end of 2011, this will start to result in more meaningful outputs. This will also enable nested studies to be produced in which monitoring data are used – such as links to prescription data, GP monitoring and death data.

8.11 The "National Drug-Related Deaths Data Collection Form" came into use in Scotland on the 1st of April 2009. This collects 80 items of data on each drug-related death grouped into:

1. personal details
2. drug using history
3. contact with drug treatment services and GPs
4. medical history
5. current substitute prescription / other prescriptions relating to drug problem
6. criminal justice information
7. scene of death
8. toxicology and cause of death.

8.12 While this will provide an essential wealth of information about the pattern and profile of drug-related deaths in Scotland, it will also provide a foundation for analysing data from both the Drug Related Deaths (DRD) and SDMD databases, which has the potential to enable the mapping of treatment engagement in relation to drug-related mortality as a core part of the process of linking datasets and improving the sophistication of the overall data monitoring system.

8.13 Furthermore, this is a building block that can be used for academic collaborations with ISD Scotland as well as linkage to other relevant data systems such as housing, criminal justice, employment and training, and child welfare and education. Thus, the possibility of having linked data on mortality, treatment uptake and possibly also treatment waiting times and prescriptions will provide a crucial foundation for the development of monitoring and mapping data that can be accessed by academics and research teams and that can provide the core set of information on which specific treatment and recovery questions can be based.

Setting a Research Agenda for Recovery from Addiction

8.14 So what are the primary knowledge gaps around recovery? At the most basic level, there is almost no descriptive information on the recovery groups and activities that take place across the ADP areas in Scotland. Similarly, there is almost no information on the impact that recovery activities taking place in Scotland have had on drug using populations and on the wider community. Reading from the recovery literature, a recovery focused research agenda would have five 'layers' of impact to be measured and assessed:

1. The number of people engaged in recovery journeys and the impact of treatment and support on their lives – measured in terms of quality of life, active engagement in communities and meaningful activities and sustained abstinence from their problem substances.
2. Measurable impact on the quality of life and functioning of family members such as the reduction in psychological health symptoms reported in the cohort of children of fathers attending AA by Andreas and O'Farrell (2009).
3. Active engagement and growth in the number of recovery communities and recovery organisations – this would include mutual aid groups like SMART Recovery and NA, but also local support groups and non-affiliated recovery support services and systems that provide visible recovery support and inspiration in local communities. This should be evaluated and tested as part of a commitment to developing an evidence base around long-term support systems that underpin developmental recovery journeys.
4. Impact on local communities in terms of the positive contribution that individuals in recovery and recovery groups can make to the lives of communities through active participation in community growth and development and economic regeneration of areas.
5. The emergence of community 'tipping points' – the most ambitious goal for recovery activities, and so for recovery research, is to show whether the impact of recovery groups and individuals fundamentally shifts the attitudes and behaviours of a community towards substance use, and so acts as a form of prevention and early intervention in high risk communities.

8.15 These five zones of potential impact and benefit should all be incorporated within a recovery research and evaluation agenda. Thus a core research requirement is to address key questions about the recovery debate by translating the definition of recovery given in the strategy into a research model that operationalises and defines key indicators and that attempts to account for each of the five types of positive recovery outcome indicated above. It is not sufficient to measure recovery by focusing only on the individual outcomes that have been the focus of addiction outcome studies to date. The basic building blocks of recovery research would include:

1. To conduct 5 to 7 year follow-ups from new help-seeking populations – this would mirror the estimated period for a 'typical' recovery journey from the point of last illicit use to a risk of use not significantly greater than for the general population as a whole. Alternatively, to attempt to access existing research populations such as that recruited for the DORIS study, the Glasgow methadone cohort or the LEAP cohort, or to collaborate in conducting longer term follow-ups for the NTORS or DORIS research cohorts in England and Scotland. By using recovery focused research instruments, the extent of recovery achievement could be assessed and the developmental pathways associated with recovery could be mapped, albeit with retrospective reconstruction. While commissioning prospective studies is expensive and means data are a long time in coming, the use of exclusively retrospective methods are limited by post hoc rationalisation and problems with sampling. Accessing existing research cohorts may provide a partial solution to this problem.
2. To identify a cohort originally recruited and accessed through SMR forms and followed up at 5 to 7 years, supplemented by additional groups for under-researched populations such as graduates from community and residential rehabilitation in Scotland, and from mutual aid groups. This would have the disadvantage of lacking satisfactory baseline information (although some basic information would be available from the SMRa form), but would enable pathways to recovery to be mapped, and there may be ethical issues arising from not obtaining client permission to contact them at the baseline data point.
3. To use general population survey methods to look at natural recovery processes in Scotland as part of the development of a recovery epidemiology. Alternatively data from the Psychiatric Co-Morbidity study in England could be used to attempt to recreate some of these data retrospectively.
4. To study planned change at the level of either treatment service providers or treatment systems (ADPs) where evaluation methods are used to test the implementation of training and culture change in services on higher level recovery outcomes and worker satisfaction measures. It is clear from the mental health recovery agenda that recovery systems need to be culturally embedded in treatment systems and attempting to map how this works, possibly on a pilot basis, will be essential in developing recovery oriented systems of care in Scottish treatment services.

8.16 Part of the proposal outlined here – as will be discussed below under funding issues – is to separate out the research agendas and their subsequent financing for acute addiction treatment and for recovery models. This is not to imply that there are not overlaps, nor indeed important continuities, but the acute model builds on an infrastructure of research that already exists to some extent in Scotland and is strong

in England, while the recovery models will use a much wider array of research techniques and are likely to involve different expert collaborators (such as those identified in chapter 5) with a view to building a new cohort of researchers focused on the long-term, developmental and community-based aspects of the recovery journey. The next section switches focus to examine a research agenda around acute treatment of substance dependence.

Developing an Evidence Base for 'What Works' in Scottish Addiction Treatment and Other Areas of Intervention

8.17 The core questions persist around the role of treatment and related interventions in promoting recovery and reducing the harms associated with illicit substance use – those related to physical and psychological health, public health, crime and the fear of crime, and protection of the children of drug using parents. This would require the development of a coherent programme of treatment research that is linked to the primary recovery agenda.

8.18 Given the concerns that have arisen in the USA literature (e.g. McLellan et al, 2006) and in the UK (Best et al, 2009) about implementation of evidence-based practice, this would also divide into two programmes – those concerned with efficacy (such as trials of new interventions and medications) and those dealing with effectiveness (such as evaluations of packages of treatment and 'technology transfer' studies). This will inevitably involve issues around workforce and the integration of recovery working practices and principles, as well as the evidence base, to a range of professional groups and those training to become:

- Addiction psychiatrists and GPs with a special interest
- Mental health nurses
- Social work staff and students
- Occupational therapists
- Psychologists
- Linked professionals such as those engaged in criminal justice, youth work, housing and vocational support and education.

8.19 While there are grounds for importing the principles of trials – using the methods of NICE, SIGN and the Cochrane and Campbell review systems, the technology transfer questions are critical in determining what actually works in applied contexts, as well as the impact of real packages of care on those seeking help for substance misuse in Scotland. This would include, but not be restricted to, some understanding of treatment pathways and technology transfer questions that would assess the 'key ingredients' including measures of therapeutic alliance (the relationship between the carer/professional and client), building of recovery capital and delivery of evidence-based psychological interventions in predicting long-term recovery journeys. It would also include questions of organisational functioning (Simpson, 2009) and the relationships between service structure and workforce development that will determine the quality of what is actually delivered to clients as packages of care in treatment. Linked to this should be a research programme that would address some of the key omissions in the addictions field generally about recovery that are particularly evident in Scotland. These would include:

- Research into engagement, retention and short and long term outcomes for abstinence oriented services, in particular detoxification and rehabilitation, and the effectiveness of linkage to 'aftercare' supports in the form of day programmes, vocational programmes, stable housing and family support programmes. While there are omissions in the knowledge base in Scotland around acute treatment, they pale into insignificance in comparison to the gaps around the transitions to long-term abstinence and ongoing engagement in recovery.
- Better understanding of the long-term impact of maintenance prescribing on functioning – including cognitive performance, motivation, self-esteem, in addition to assessments of the provision of recovery support within maintenance treatment programmes. Scotland has a large number of clients on long-term prescribing and it is essential that the recovery potential of this group is assessed and that pilot projects are evaluated in order to initiate recovery activities within maintenance treatment services.
- The delivery of real choices to clients in treatment around medication (particularly methadone or buprenorphine, but also including dihydrocodeine) and about the intensity and type of psychosocial packages that are offered alongside medications. Crucial to this area of investigation would be assessments of the options for detoxification and the development of support systems (including linkage to mutual aid and other community groups) to assess the impact on the risk of relapse.
- A wider programme looking at the support and delivery of brief and intensive psychosocial programmes to stimulant users, non-dependent opiate users in the criminal justice system and problem users of other drugs. The treatment system has been developed primarily around injecting heroin users and this has led to a reliance on substitute prescribing that excludes users of other substances and may provide sub-optimal service delivery to polydrug users, including those who switch from opiates to alcohol.

The Development of an Oversight System

8.20 In addition to the recovery-specific agenda and the addictions interventions agenda outlined in Chapter 7, there is also the broader array of prevalence, prevention, education and public health questions some of which are specified in Chapter 7 following the consultation with key experts in the drugs evidence field The suggestion made for a Drug Research Forum in Chapter 7 would seem to fall naturally within the remit of the National Drug Evidence Group with potentially three research subgroups dealing with the three broad areas that have been synthesised from the review chapters and the interviews conducted with key experts. These areas are about building on the existing research work, that focus more directly on recovery and that then link into wider policy and public wellbeing agendas:

1. recovery-specific research
2. addictions treatment and intervention research
3. wider questions of public health, prevention, education and prevalence and patterns of drug use.

8.21 This forum would have four main objectives:

1. To develop a research agenda using the outline above as the starting point. This would link to the Drugs Evidence Framework that, at the time of writing, is being drafted on behalf of the National Drug Evidence Group. The Research Evidence Framework provides the initial outline of key areas that will require prioritisation through NDEG, and then construction of a research programme to be consulted upon with a range of key stakeholders.
2. To bring together academics, policy-makers, practitioners and those involved in standard data monitoring to establish a consensus and to agree on collaborations and targets for research.
3. To liaise with equivalent figures in England and internationally to link into ongoing work in other places (such as the recovery research work being conducted in the USA, and the monitoring research done by the NTA in England), to participate in multi-site research collaborations and to seek international funding sources.
4. To generate a research culture both by attempting to generate funding from governmental and external bodies and by promoting an evidence-based culture in the planning, commissioning and delivery of services in which – in addition to formal monitoring returns – simple levels of audit and evaluation can also contribute to the knowledge base. Part of this latter function would also be to generate a local knowledge repository for Scotland and to ensure the dissemination of key knowledge to relevant practitioners and planners and to national and local government.

Funding the Work of the Forum

8.22 The key experts participating in the consultation stage of this research provided information on a wide-range of potential funding sources – listed in Chapter 7 - and one of the first tasks of the suggested Scottish Drug Research Forum could be to engage with these groups to discuss their willingness to participate in a dialogue with the group about the opportunities for any potential funding consortiums – and to approach government about the possibility of matching any funding that was drawn from these sources. As part of the interview process, one of the main charitable bodies, Lloyds TSB Foundation, has already expressed a willingness to participate in such discussions.

8.23 However, one of the key lessons from a recovery agenda is that we need to move away from a 'silo' model of addictions to something much more ambitious and broad-ranging. The key successes of recovery, as outlined throughout this report, go way beyond individual recovery pathways to look at families, communities, regeneration and prevention. For this reason, research investigations around recovery – and indeed the funding of services – should not be confined by the label of addiction. As a consequence, the key agenda that recovery research should be tapping into is a much broader question around social inclusion and community development (which should complement but not compete for funds with traditional clinical research) where recovery already plays a key role but one that is poorly charted by academics and where there is a limited academic heritage from an addictions perspective. Thus, one potential area for funding of research and of service delivery is around local government and communities work and this is also a potential source for collaboration with academics from a different disciplinary

backgrounds. Likewise, the core aim of recovery in disrupting inter-generational transmission means that a similar set of funding opportunities and collaborations arise with family services and research funders into family work. There are potentially similar opportunities around housing, social care, employment, education and training, and in extending the aims of prevention to wider community issues.

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APPENDICES

Appendix 1: Review of documents cited in *The Road to Recovery* and analysis of their relevance to recovery and the evidence base

Appendix 2: Independent Funding Sources

Appendix 1: Review of documents cited in *The Road to Recovery* and analysis of their relevance to recovery and the evidence base

Source 1	**Reducing Re-offending: National Strategy for the Management of Offenders**
Author(s)	Scottish Executive
Year	2006
Format/Availability	PDF
Type of Paper	First national offender management strategy
Purpose of Paper	To set a target of 2% reduction in reconviction rates in all types of sentences by March 2008.
Original Data	No
Evidence Quality	Not applicable
Intervention	To elicit 'sustained or improved physical and mental wellbeing; the ability to access and sustain accommodation; reduced or stabilised substance misuse; improved literacy skills; employability prospects increased; maintained or improved relationships with families, peers and community; the ability to access and sustain community support; the ability to live independently' (p5).
Effect	Focus on interagency working for sharing of resources expertise and information, 'to support transitions, particularly from prison to the community' (p16).
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	One of the aims is challenging barriers and stigma to reintegration through communication and information management.
Relevance to Recovery (Service)	One of the key aims is to focus on integrated case management and to 'promote the enhanced through-care strategy, including the Through-care Addiction Service' (p17).
Relevance to Recovery (System)	The aim is to use existing partnership forums such as community planning, community safety partnerships and community health partnerships to engage with community partners like employability, learning and housing.
GAPS/IMPLICATIONS/QUESTIONS	Paragraph 5.4 asserts that 'we would understand more about the effectiveness of work with offenders if more of the data available came from studies which tracked individuals through the system, rather than from statistical 'snapshots''(p28). The strategy also suggests that data should examine the rates of re-offending and the seriousness of offences.

Source 2	Prisoner Survey
Author(s)	Scottish Prison Service
Year	2008
Format/Availability	PDF
Type of Paper	Annual survey of prisoners
Purpose of Paper	'The survey is not simply about asking prisoners their views. The survey is about helping inform and shape change in the SPS and is directed at improving the quality of service delivery in every prison.'
Original Data	Original survey data
Evidence Quality	Cross-sectional survey that achieved an overall response rate of 62% of all adult prisoners in Scotland – response rate down from 74% in 2007.
Intervention	52% of prisoners reported that they had been assessed for drug use on admission to prison; 47% reported that they had been offered help with their drug problem in prison; 28% reported that their drug taking would be a problem for them on their release.
Effect	No data provided on the type, duration or effectiveness of interventions delivered in prison.
Sample size	Not stated
Relevance to Scotland/ Technology transfer issues	Survey conducted in Scotland with good coverage and high response rate.
Relevance to Recovery (Individual)	21% had been receiving treatment for their drug use prior to their imprisonment, and 22% had committed their offence to get money for drugs suggesting a strong linkage and the need for effective continuity of care.
Relevance to Recovery (Service)	High rates of drug use were reported in the 12 months before coming into prison – heroin (49%), cocaine (63%), benzodiazepines (60%) and cannabis (81%).
Relevance to Recovery (System)	28% reported that their drug use would be a problem for them on release, although 45% reported that they would be willing to seek help on their release.
GAPS/IMPLICATIONS/QUESTIONS	The report does not provide information on the quality or continuity of treatment in prison (nor on prisoners satisfaction with treatment delivered) nor about ongoing needs for recovery in and after prison.

Source 3	**It's Everyone's Job to Make Sure I'm Alright: Report of the Child Protection Audit and Review**
Author(s)	Scottish Executive
Year	2002
Format/Availability	PDF
Type of Paper	Report to improve the sageguarding of vulnerable children
Purpose of Paper	'To promote the reduction of the abuse or neglect of children; to improve the services for children who experience abuse or neglect; to review how well agencies work together and public and professional confidence in these agencies; to identify best practice; to learn lessons from international developments' (p19).
Original Data	Case audit of 188 child protection files; this yielded 11 interviews with children; analysis of Childline and Parentline calls; MORI Scotland survey of public knowledge and understanding of child protection system; questionnaire survey of academics, statutory and voluntary agencies and MSPs.
Evidence Quality	Low response rates to questionnaires and child interview processes
Intervention	'Drug Action Teams and Child Protection Committees are working on reducing the problems arising from parental drug and alcohol misuse' (p143).
Effect	76/188 cases assessed involved children living with substance abusing parents. Concluded that many children live in circumstances that are not acceptable and many children and their parents do not have confidence in the system. 'Agencies are not able to always respond effectively to some problems – parental drug or alcohol misuse, domestic abuse and neglect' (p140).
Sample size	As above
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Not applicable
Relevance to Recovery (Service)	Not applicable
Relevance to Recovery (System)	Integrated working with child protection committees to improve information sharing, training and awareness of staff and effective inter-agency working.
GAPS/IMPLICATIONS/QUESTIONS	Insufficient needs assessment of newborn children to substance using parents and parents with a history of neglect.

Source 4	**Hidden Harm. Responding to the Needs of Children of Problem Drug Users**
Author(s)	Advisory Council on the Misuse of Drugs (ACMD)
Year	2003
Format/Availability	PDF
Type of Paper	Summary of evidence – review
Purpose of Paper	To summarise the findings of the inquiry in relation to a series of questions – to estimate the number of children affected by parental substance use; to examine the effects of parental drug use on children; to consider the levels of involvement of key provider agencies; to identify best practice.
Original Data	Witness testimony; secondary data analysis on prevalence; survey analysis of treatment, maternity and social services.
Evidence Quality	Good quality evidence from expert testimony; medium quality level for survey data and lower level for epidemiological assessment.
Intervention	Not applicable
Effect	Evidence of marked inconsistencies in the delivery of interventions in each of the surveyed settings with variation in specialist services, integrated working and provision of help for parents. Limited research information base around risks to drug users and families particularly in the UK context.
Sample size	Survey had overall response rate of 55%.
Relevance to Scotland/ Technology transfer issues	Scotland included as part of overall UK analysis.
Relevance to Recovery (Individual)	Not explicitly targeted but focus on improving family functioning consistent with a recovery approach**.**
Relevance to Recovery (Service)	Recommended that there was much greater focus on adequate recording of dependent children by specialist services and that these services should 'contribute actively to meeting their needs'. The report also called for better training for staff and for specialist services to provide more effective supports for drug users and their children.
Relevance to Recovery (System)	Expressed the need to listen to the voices of children **–** need for delivery of a coordinated range of resources to provide support to families.
GAPS/IMPLICATIONS/QUESTIONS	'A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from conception to adolescence'.

Source 5	**Getting Our Priorities Right: Good Practice Guidance for Working with Children and Families Affected by Substance Misuse**
Author(s)	Scottish Executive
Year	2003
Format/Availability	PDF
Type of Paper	Guidance to improve the lives of children affected by parental substance misuse.
Purpose of Paper	To outline what agencies need to ask of families presenting with drug and alcohol problems; to advise on the help available and on inter-agency working and the issues to be addressed to strengthen services and help workforce development in this area.
Original Data	No
Evidence Quality	Not applicable
Intervention	'All agencies in contact with children and their families have a responsibility to act if they become worried about a child's welfare or a parent's ability to care for the child safely and adequately. The welfare of the child is the paramount consideration'. Also required all agencies working with substance misusing parents to have child protection procedures in place.
Effect	Appendix 2 contains a basic checklist for professionals on collecting information about substance use and its impact on parenting.
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Primarily through the commitment to family working and the emphasis on support services for the whole family.
Relevance to Recovery (Service)	Need for shared information and common protocols for specialist substance misuse agencies to work with partner agencies.
Relevance to Recovery (System)	The report made a major commitment to strengthening services for families; and to building strong inter-agency partnerships – and that Drug and Alcohol Action Teams should work to ensure that common policies and protocols are in place for working with families.
GAPS/IMPLICATIONS/QUESTIONS	No clear presentation of evidence and no research about implications on recovery for individuals or families.

Source 6	**Hidden Harm – Scottish Executive Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs**
Author(s)	Scottish Executive
Year	2004
Format/Availability	PDF
Type of Paper	Response to Hidden Harm report
Purpose of Paper	To set out the Scottish context and the framework for the response to the challenges set out in Hidden Harm, and to set the agenda for Hidden Harm New Agenda Steering Group.
Original Data	No
Evidence Quality	Not applicable
Intervention	Aims to set out appropriate performance indicators and include a wide range of agencies including primary care providers and schools within this performance framework. Full response given to each of the 48 recommendations of the Hidden Harm report.
Effect	Scottish Executive had already commissioned research on babies of substance misusing mothers and an evaluation of young people's projects, and indicates the need to extend this work to alcohol.
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland.
Relevance to Recovery (Individual)	Proposed link to review of treatment and rehabilitation services.
Relevance to Recovery (Service)	The report requires improvements in data collection, training for workers and integration between drug services, children's services and child protection services. Particular emphasis in the report is placed on criminal justice and the potential role of Drug Treatment Testing Orders (DTTOs) in targeting women offenders.
Relevance to Recovery (System)	Although the focus is not on recovery, the response emphasises the need for systemic working and information sharing and joint case management that are relevant to the recovery agenda.
GAPS/IMPLICATIONS/QUESTIONS	No explicit focus on recovery, nor on the potential gains for families of parental recovery.

Source 7	Protecting Children and Young People: Framework for Standards
Author(s)	Scottish Executive
Year	2004
Format/Availability	PDF
Type of Paper	Pledge to children and young people at risk of abuse or neglect.
Purpose of Paper	A charter which 'sets out what children and young people need and expect to help protect them when they are in danger of being, or already have been, harmed, by another person' (p3).
Original Data	No
Evidence Quality	Not applicable.
Intervention	A programme of reform of child protection services and programme for working with agencies and professionals to deliver the pledge.
Effect	The aim is to encourage agencies and professionals to 'reflect on practice and deliver the commitments made in the Charter; avoid duplication of effort; identify ways in which outcomes for children can be improved; and help to plan, as single agencies and jointly, for these improvements' (p9).
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Not applicable
Relevance to Recovery (Service)	Focus on multi-agency working and requiring the role of single lead professionals to coordinate assessments, plans and reviews (p11).
Relevance to Recovery (System)	'Taking account of the needs of the child and their parents, professionals, working together' (p17) to focus on needs and risks, personal and family strengths, support networks and resources available, and the gaps that need to be filled and the resources and options to fill them. There is also a focus on the role of communities in protecting children and developing appropriate strategies.
GAPS/IMPLICATIONS/QUESTIONS	None relevant to recovery.

Source 8	**Hidden Harm - Next Steps: Supporting Children - Working with Parents**
Author(s)	Scottish Executive
Year	2006
Format/Availability	PDF
Type of Paper	Policy update document
Purpose of Paper	To set out what the Scottish Executive was doing with partners to bring about the improvements required in the Hidden Harm document – 'to improve the way in which agencies identify, protect and support children and young people living with parental substance misuse'**.**
Original Data	No
Evidence Quality	Not applicable
Intervention	Legislating to require the sharing of information; placing a duty on all agencies to identify the needs of children; and early and better identification of vulnerable children.
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Parenting support for fathers in the criminal justice system; relationship counselling as part of the Routes Out of Prison project; improved support for young people caring for parents with substance misuse problems.
Relevance to Recovery (Service)	Requirement for information sharing and inspection of specialist services to assess the impact of specialist working on children. Improve training for specialist staff.
Relevance to Recovery (System)	Requirement for suitable housing for vulnerable families. Each ADP responsible for safeguarding and promoting the interests of children of drug using parents.
GAPS/IMPLICATIONS/QUESTIONS	Although recommendations are laid out, little indication of effective practice and examples of success.

Source 9	**Looked After Children and Young People: We Can and Must Do Better**
Author(s)	Scottish Executive
Year	2007
Format/Availability	PDF
Type of Paper	Report to initiate improved outcomes for looked after children.
Purpose of Paper	To promote five key outcomes for looked after children – 'working together; becoming effective lifelong learners; developing into successful and responsible adults; being emotionally, mentally and physically healthy; feeling safe and nurtured in a home setting' (p1).
Original Data	No
Evidence Quality	Not applicable
Intervention	Improved training for parents, foster carers, residential workers and teachers. Funding 18 local authorities to take forward pilot work to improve educational outcomes for looked after children.
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Emphasis on safe, secure and appropriate accommodation for looked after young people.
Relevance to Recovery (Service)	Care Commission tasked to review the health of looked after children and young people.
Relevance to Recovery (System)	Focus on partnership approaches "with local authorities to deliver a more robust and comprehensive data collection and reporting framework" (p16). Also emphasises the importance of continuity of care and sensitivity around transition points.
GAPS/IMPLICATIONS/QUESTIONS	None relevant to recovery.

Source 10	**Getting It Right for Every Child in Kinship and Foster Care**
Author(s)	Scottish Government
Year	2007
Format/Availability	PDF
Type of Paper	Strategy document
Purpose of Paper	'The purpose of this kinship and foster care strategy is to demonstrate the commitment of the Scottish Government and local government, firstly to the children and young people concerned and secondly, to those who care for them…. And to ensure that children and families receive personalised care, which meets their complex needs over time'.
Original Data	No
Evidence Quality	Not applicable
Intervention	Aim is to ensure that all children are safe, nurtured, healthy, achieving, active, respected, responsible and included.
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	One of the key aims of the strategy is to strengthen the capacity of the family to look after a child.
Relevance to Recovery (Service)	Emphasises the need for an increased focus on the family and putting the needs and wishes of the child at the centre of the treatment and recovery process.
Relevance to Recovery (System)	The systemic implications are around working with whole families and effective information sharing and joint working approaches that support and enable recovery to occur within the family context.
GAPS/IMPLICATIONS/QUESTIONS	There is little focus on recovery or its impact on the family within the document and no presentation of original evidence.

Source 11	Evaluation of the Effectiveness of Drug Education in Scottish Schools
Author(s)	M. Stead, A.M. MacKintosh, L. McDemott, D. Eadie, M. Macneil, R. Stradling and S. Minty
Year	2005
Format/Availability	PDF
Type of Paper	Report of multi-method evaluation
Purpose of Paper	'Multi-phase study conducted to examine the nature and effectiveness of current drug education practice in Scotland' (p7).
Original Data	In addition to a literature review, there was a postal survey of schools, sample observations in schools and qualitative research with young people. A total of 100 classroom observations were carried out.
Evidence Quality	Postal survey yielding data from a sample of 528 primary school pupils and 357 secondary school pupils. From the observations, just over half of the lessons were considered to have helped the understanding of students.
Intervention	The authors concluded that information provision was the main form of delivery and that lessons were not as interactive as they could have been, with limited evidence of progression across the years in the content of delivery.
Effect	From the survey, 65% of P1 groups surveyed provided some drug education rising to 94% for P7 groups. In contrast in secondary schools, drug education was more likely to be delivered in the earlier years ranging from 94% of S1 and S2 classes to 84% of S4 classes reported to having received drug education. In secondary schools, the two main barriers to the delivery of drug education were staff training and timetabling issues.
Sample size	As above
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Not applicable
Relevance to Recovery (Service)	Not applicable
Relevance to Recovery (System)	Not applicable
GAPS/IMPLICATIONS/QUESTIONS	'Overall, it is clear that there is much good practice in Scotland in drug education, but more can be done to enhance its effectiveness, particularly through clearer guidance on evidence-based methods and approaches, and on continuity and progression; further training and support to boost teachers' knowledge, skills and confidence; and more attention to resources' (p204).

Source 12	**Early Years and Early Intervention: A Joint Scottish Government and COSLA Policy Statement**
Author(s)	Scottish Government and COSLA
Year	2008
Format/Availability	PDF
Type of Paper	Joint Scottish Government and COSLA policy statement on 'early years and early intervention'.
Purpose of Paper	A framework for a strategic approach to the early years prioritizing resources across local government, the health service and the public sector.
Original Data	No
Evidence Quality	Not applicable
Intervention	The aims of the document are to reduce inequalities, identify those at risk of not achieving, to make sustained and effective interventions and to switch to a model that focuses on capacity building in families and communities.
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Focus on personalisation of services, with an emphasis on risk, need and resilience; help parents and carers provide a 'nurturing and stimulating home environment'.
Relevance to Recovery (Service)	Developing more people-centred services working alongside people and not constrained by service boundaries; focus on workforce development to increase 'people-centred' approaches.
Relevance to Recovery (System)	The focus on capacity building in individuals, families and communities and to maximise life chances is consistent with a recovery model; emphasis on 'what works and on evidence-based approaches'.
GAPS/IMPLICATIONS/QUESTIONS	While recognizing the need for 'identifying effective interventions' it is not made clear how this will be done and what the link to adult or community recovery will be – the document does not have vulnerable parents as a target.

Source 13	Evaluation of the 'Know the Score' Drugs Campaign
Author(s)	D. MacLean, J. Gilliatt & J. Brogden, Scottish Executive
Year	2002
Format/Availability	PDF
Type of Paper	Evaluation
Purpose of Paper	Review of multi-agency drugs campaign designed to increase activity against drugs dealers; increase drug awareness; encourage healthy lifestyles; provide diversionary activities for young people; publicise supports available and reduce drug-related harms.
Original Data	80 interviews with representatives of organisations involved; 8 workshops involving 140 participants; survey of Drug Action Teams and secondary analysis of data on enforcement, publicity, and campaign activities.
Evidence Quality	Mid-level data quality – data all cross-sectional and no standardised evaluation criteria using pre- / post-design.
Intervention	Press and radio coverage reached an estimated 22% of the Scottish population; a total of 1200 events took place – mission statement was to 'take effective law enforcement action against those involved in the supply and trafficking of illegal drugs, and to promote drugs awareness and harm reduction, in partnership with the public and other agencies'.
Effect	Increase in the number of recorded drug offences by 12%; and increase by £10 million in the value of drugs seized (from £5m to £15m) 'drug seizures rose by 177% during the campaign period'; positive feedback from the workshops; evaluated as improving existing partnerships. However, recognition of variable impact across police force areas.
Sample size	'Between the interviews with steering group members, interviews at force level, and the workshops, approximately 200 people' contributed to the results.
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Not applicable
Relevance to Recovery (Service)	Identified key problems around partnership working and coordination across Scotland.
Relevance to Recovery (System)	'Overall the campaign did not achieve the degree of commitment or partnership hoped for' – attributed to lack of time, lack of awareness and the central role of the police in coordination (p22).
GAPS/IMPLICATIONS/QUESTIONS	Evaluation limited by 'lack of specificity, or measurability of the objectives of the campaign', the absence of a baseline and locally set objectives (p30).

Source 14	Review of Choices for Life
Author(s)	J. Menzies and K. Myant, Ipsos MORI; Scottish Executive Social Research
Year	2006
Format/Availability	PDF
Type of Paper	Review of Choices for Life – series of events designed to promote healthy lifestyles and increase drug awareness to primary school pupils about to make the transition to secondary school.
Purpose of Paper	Presents the results of two surveys of Primary 7 pupils.
Original Data	Survey data supplemented by discussion groups and in-depth interviews with teachers.
Evidence Quality	Pre and post intervention assessments using qualitative and quantitative methods with large sample size (around 1,700 at each time point) – but no follow-up assessment of impact on behaviour.
Intervention	The events last around two hours and included live music, a school choir singing the Choices for Life song, a quiz about drugs, alcohol and smoking, video clips and a play.
Effect	Because of strong anti-drug baseline opinions, the surveys recorded very little change in opinions – main effect was to reinforce negative views. High level of recall about the event was reported among pupils who had attended in the previous year. 'However, the events provide more affective or emotional messages: the pupils now feel they have more awareness of what could happen if they use drugs and feel they have more confidence to handle situations where they are offered them' (p30).
Sample size	Quantitative – 1,714 pre-assessments and 1,691 post-assessments; 8 interviews with teachers; 16 discussion groups with Primary 7 pupils; 16 discussion groups with S1 pupils to look at longer term effects.
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Not applicable
Relevance to Recovery (Service)	Not applicable
Relevance to Recovery (System)	Not applicable
GAPS/IMPLICATIONS/QUESTIONS	No outcome analysis to assess impact on drug uptake in secondary school; authors concluded that 'there was limited follow-up education to capitalise on (this) interest' (p7). Authors recommend that the views of participants are taken at intervals as they progress through school. 'Over the long term, this would allow actual behaviour to related to attend (sic) at Choices events rather than relying on current perceptions of future behaviour' (p31)

Source 15	**Pathways to Problems; Hazardous Use of Tobacco, Alcohol and Other Drugs by Young People in the UK and Its Implications for Policy**
Author(s)	Prevention Working Group, Advisory Council on the Misuse of Drugs
Year	2006
Format/Availability	PDF
Type of Paper	Prevention Working Group Review for older age group following on from Hidden Harm.
Purpose of Paper	'To take a fresh look at the patterns, trends and determinants of early use of psychoactive drugs by young people in the UK'.
Original Data	No – review of existing information.
Evidence Quality	Not a systematic review; expert testimony to ACMD group consisting of a range of eminent practitioners, policy makers and academics.
Intervention	Scottish data presented showed that 'increasing area deprivation was associated with increased prevalence of regular drinking, smoking and recent cannabis use among girls but not boys' (P57). Similar Scottish data were presented showing the link between deprivation and hospital admissions (p63).
Effect	'A number of systematic reviews have found that some skills-based drugs education programmes in schools had limited effectiveness in preventing substance use in the shorter term, but there was evidence of long-term impact. It has not yet been possible to identify the components of skills-based programmes that are necessary for effectiveness' (p74).
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	UK wide but several of the key data sources are Scottish, including the Edinburgh Youth Transitions Study.
Relevance to Recovery (Individual)	Comment on patterns of change – 'Many young people use drugs intermittently at different stages of their lives. In the mid-twenties, reducing use or stopping becomes more common than starting. This is usually without professional help and is often associated with marriage and stable employment' (p52).
Relevance to Recovery (Service)	Not applicable
Relevance to Recovery (System)	Identification of high risk groups as involving use by parents or siblings; family conflict or poor parenting; truancy and other forms of delinquency; pre-existing behavioural problems; low parental supervision; and living with a single or step-parent.
GAPS/IMPLICATIONS/QUESTIONS	Report identified need for large scale periodic surveys of 11-15 year olds; a longitudinal study or a representative group of 15-30 year olds and improved evidence on good parenting and stable family life. 'In the light of the evidence that classroom-based drugs education has very limited effectiveness in reducing rates of drug use, there should be a careful reassessment of the role of schools in drug misuse prevention' (p12).

Source 16	**Review of Research on Vulnerable Young People and their Transitions to Independent Living**
Author(s)	S. Elsey, K. Backett-Milburn and L. Jamieson, Centre for Research on Families and Relationships, University of Edinburgh
Year	2007
Format/Availability	PDF
Type of Paper	Review of research on vulnerable young people and their transitions to independent living.
Purpose of Paper	To draw together evidence on successful transitions for young people out of care settings and to look at the evidence around housing transitions.
Original Data	Review article
Evidence Quality	Not a systematic review – described by the authors as 'a thorough scoping exercise', including published and 'grey' literature.
Intervention	Not applicable
Effect	According to Scottish Exclusion Unit (2005) there are a minority of children who have early exit from education combined with multiple transitions – this group are typically lacking in family support, and multiple moves often signal marginalisation and social exclusion.
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland but limited Scottish evidence to draw upon.
Relevance to Recovery (Individual)	It is recognised that 'problems with health, particularly mental health and misuse of alcohol and drugs are more prevalent'.
Relevance to Recovery (Service)	'Young people themselves have been critical of the timing and inadequate preparation for leaving care'.
Relevance to Recovery (System)	Complex needs, including drug and alcohol problems, can lead to problems in accessing resources, particularly accommodation. Additionally, many young people leave care poorly equipped to cope with the demands of life
GAPS/IMPLICATIONS/QUESTIONS	'There are not any long-term studies in Scotland on outcomes for young people leaving care. There are, therefore, no studies which attempt to disaggregate the impact of individual factors and interventions on young people'. Review does not mention the impact of recovery on effective transitions.

Source 17	Mental Health in Scotland: Closing the Gaps – Making a Difference: Commitment 13
Author(s)	Mental Health and Substance Misuse Advisory Group, Scottish Government
Year	2007
Format/Availability	PDF
Type of Paper	Guidance on care and support for people with co-occurring substance misuse and mental health problems
Purpose of Paper	To improve the awareness of co-occurring mental health and substance misuse problems; to improve support and service provision for people who have both mental health and substance misuse problems (and their carers); and to reduce stigma and influence positively attitudes towards this care group.
Original Data	No
Evidence Quality	Literature review and contributions of an expert advisory group
Intervention	Not applicable
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Recommendations for care and support for people with co-occurring substance misuse and mental health problems. Data on the extent of the need appears to be UK wide or English, small scale studies in Glasgow.
Relevance to Recovery (Individual)	Dual recovery process, obtaining employment can be doubly difficult
Relevance to Recovery (Service)	Service user survey implies that current drug treatment services are not responsive to the needs of people with mental health problems since this group tend to abuse alcohol, cannabis and cocaine rather than opiates. Assessment tools to record co-morbidity systematically are required
Relevance to Recovery (System)	Recommendations that people with co-occuring severe mental health problems and substance misuse problems should be treated within mental health services
GAPS/IMPLICATIONS/QUESTIONS	Lack of clear evidence for Scotland (outside Glasgow) as to the extent of co-morbidity of mental health problems and substance abuse. Lack of evidence around the usage patterns of people with mental health problems.

Source 18	**Drug Misuse and Dependence: UK Guidelines on Clinical Management**
Author(s)	Department of Health (England) and the devolved administrations (the Scottish Government, Welsh Assembly Government and Northern Ireland Executive)
Year	2007
Format/Availability	PDF
Type of Paper	Clinical Guidelines
Purpose of Paper	"Intended for all clinicians in the UK, especially those providing pharmacological interventions for drug misusers as a component of drug misuse treatment".
Original Data	No
Evidence Quality	Working group
Intervention	Not applicable
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Document based on the decision to issue a single set of guidelines for the whole of the UK - skeleton framework of best practice from which the devolved administrations could develop their own guidance on locally appropriate variations in policy and practice.
Relevance to Recovery (Individual)	The Clinical Guidelines outline the basis for providing clinical treatment to all people resident in the UK requiring substance misuse treatment. This document directly influences the way care is provided to drug misusers.
Relevance to Recovery (Service)	The document highlights a number of gaps in the evidence-base for drug treatment research and so this is obviously important in terms of 'recovery'. However, the publication mainly deals with pharmacological interventions.
Relevance to Recovery (System)	Review of the evidence-base for a range of drug misuse treatment-related issues, including: prison drug treatment; drugs and driving; injectable opioid treatment; methadone and buprenorphine dose induction; drug testing and its use in practice; drug treatment for young people; treatment of substance misuse in pregnancy; cardiac assessment and monitoring for methadone prescribing.
GAPS/IMPLICATIONS/QUESTIONS	2007 Guidelines state: 'Although the evidence base for drug misuse treatment has improved, the working group found that, in many areas of drug treatment, evidence was either lacking or was based on research from countries other than the UK'. Evidence suggests that methadone is more likely to retain patients in treatment but the evidence for the relative effectiveness of methadone and buprenorphine at preventing illicit opioid misuse is mixed – further research is required. Since the advent of supervised consumption, the number of drug-related deaths involving methadone has reduced, during a period when more methadone is being prescribed, providing indirect evidence that supervising the consumption of medication may reduce diversion - research required. Evidence for the effectiveness of take-home naloxone in preventing overdose-related deaths in opiate misusers is largely anecdotal at present.

Source 19	National Quality Standards for Substance Misuse Services
Author(s)	Scottish Executive
Year	2005
Format/Availability	PDF
Type of Paper	Policy document
Purpose of Paper	To set out a framework of standards to ensure consistency in the provision of all substance misuse services.
Original Data	No
Evidence Quality	Not applicable
Intervention	Not applicable
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Standards developed for specifically for Scotland
Relevance to Recovery (Individual)	The standards have been developed from the standpoint of the people who use these services. 'They describe what each person can expect from the service provider. They focus on the progress that the person using the service can make during a period of treatment'.
Relevance to Recovery (Service)	Describes a 'number of different programmes relevant to the quality improvement and underpinning development of standards in substance misuse services'.
Relevance to Recovery (System)	The standards are intended to guide those involved in tackling substance misuse (such as service commissioners and planners) in terms of policy development and funding.
GAPS/IMPLICATIONS/QUESTIONS	No standards set thereby creating difficulty in benchmarking standards at local or national level No agreed measurement units resulting in lack of uniformity of measurement Lack of any national process or system for applying these standards to practice. This results in a gap in knowledge regarding how to apply these standards, how to measure and how to evaluate them.

Source 20	**National Investigation into Drug-Related Deaths in Scotland, 2003**
Author(s)	Zador D, Kidd B, Hutchison S, Taylor A, Hickmann M, Faley T, Rome A and Baldacchino A.
Year	2005
Format/Availability	PDF
Type of Paper	Report
Purpose of Paper	To investigate and report on causes and circumstances of drug related deaths in Scotland.
Original Data	Yes
Evidence Quality	Data on the 317 drug related deaths in Scotland in 2003 was collected from the General Register Office for Scotland (GROS), police, prisons, Crown Office, primary care, mental health services, criminal justice services and drug services. In addition, primary research was conducted with overdose survivors sampled from Glasgow and fatal overdoses were compared with data from London coronial courts.
Intervention	Not applicable
Effect	Not applicable
Sample size	317 (all drug related deaths in Scotland 2003)
Relevance to Scotland/ Technology transfer issues	Based on Scottish data regarding drug related deaths. Drug overdose survivors in Glasgow may not be representative of the wider substance misusing population in Scotland. Likewise, quantitative comparisons between Scotland DRDs and London DRDs may not be representative.
Relevance to Recovery (Individual)	89% of drug related deaths had received no counselling in the six months prior to their death.
Relevance to Recovery (Service)	The study found that nearly half of all deaths occurred when other people were present and demonstrated a clear reluctance in those present to call for help. Most deaths involved more than one drug and over half involved alcohol.
Relevance to Recovery (System)	People most at risk are in contact with services. Most often these are non-specialist services such as primary care, criminal justice social work and mental health services. This requires better sharing of information and communication between services.
GAPS/IMPLICATIONS/QUESTIONS	Research gaps relate to lack of research evidence regarding strategies to reduce the risk of overdose, evidence of effective practice in the UK that has been subject to evaluation and the lack of information on the views of drug users and their families in how to improve the management of overdose situations.

Source 21	**Workforce Plus – An Employability Framework for Scotland**
Author(s)	Scottish Executive
Year	2006
Format/Availability	PDF
Type of Paper	Strategy document
Purpose of Paper	To set out an agenda on how to achieve the target of getting 66,000 individuals, in seven local government areas, to move from benefits to work within Scotland.
Original Data	No
Evidence Quality	Not applicable
Intervention	Not applicable
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Framework specific to Scotland, though this is part of a UK employability agenda.
Relevance to Recovery (Individual)	Makes mention of the importance of making the necessary link to work for people with substance misuse problems and those with related issues such as mental health problems and homelessness.
Relevance to Recovery (Service)	The framework outlines the roles and responsibilities of different services to make a significant contribution to employability prospects of individuals and attempts to demonstrate how links can be made between organisations to help achieve such a goal.
Relevance to Recovery (System)	Although recovery is not specifically mentioned in this document, employability is considered to be a key goal in the long-term process of recovery from substance misuse, and so it is vital to implement a Scottish strategy that focuses on this aspect.
GAPS/IMPLICATIONS/QUESTIONS	The Workstream identified that 'there is some evidence that support for disadvantaged clients are too short term and expertise often lost between the end of funding for one project to the start of another'. Also that 'there is a perception that the needs of some groups are met in a way that separates them unnecessarily from other groups'. In addition, it was noted that existing services tend to focus on the job ready and there are gaps in current provision, particularly in terms of early engagement and in-work support'.

Source 22	Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008 - 2011
Author(s)	Scottish Government (DG Health and Wellbeing)
Year	2007
Format/Availability	PDF
Type of Paper	Outline of 'proposed future direction for mental health improvement and population mental health for 2008 – 2011'.
Purpose of Paper	To promote a vision of mental health as central to wellbeing based on the idea that 'someone can experience signs and symptoms of mental illness and still have good or flourishing mental wellbeing' (p3).
Original Data	No
Evidence Quality	Not applicable
Intervention	Targets the mental health and wellbeing of the whole population, addressing risk and protective factors; supplemented by the targeting of vulnerable populations. The three main themes are promoting mental health, preventing mental illness and supporting improvements in 'quality of life, social inclusion, health, equality and recovery' (p4).
Effect	Target populations include people with alcohol and drug problems, and other excluded groups.
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Report promotes the notion that 'recovery in the presence or absence of the symptoms of mental illness is possible and will be individual to each person and their circumstances' (p9). A key area for consideration within the report is around co-morbidity.
Relevance to Recovery (Service)	It is recognised that 'Belief in recovery is key to tackling stigma and discrimination and improving people's quality of life, inclusion and opportunities' (p9). Action 4 requires 'improvement of attitudes and behaviours within staff groups' (p12).
Relevance to Recovery (System)	Action 5 includes a requirement to make effective linkages to other key public health agendas including alcohol and drugs.
GAPS/IMPLICATIONS/QUESTIONS	One of the key aims is to develop 'a local understanding of individual and community mental wellbeing, building on work in NHS Health Scotland on mental health indicators, to record baselines and to assist in assessing effectiveness of programmes of work and changes in local population mental wellbeing' (p11).

Source 23	Hepatitis Action Plan for Scotland, Phase II: May 2008 – March 2011
Author(s)	Scottish Executive
Year	2008
Format/Availability	PDF
Type of Paper	Action Plan
Purpose of Paper	To address the issues underlying the spread of Hepatitis C in 1% of the Scottish population and to propose actions that the Scottish Executive can undertake to tackle Hepatitis C in Scotland.
Original Data	No
Evidence Quality	No original data
Intervention	Not applicable
Effect	Not applicable
Sample size	Not stated
Relevance to Scotland/ Technology transfer issues	Action plan for Scotland
Relevance to Recovery (Individual)	Individuals who inject drugs along with those who have developed hepatitis C will be made more aware of the dangers of the re-use and sharing of needles.
Relevance to Recovery (Service)	No relevant information
Relevance to Recovery (System)	No relevant information
GAPS/IMPLICATIONS/QUESTIONS	Over 85% of the individuals infected with Hepatitis C are infected through the use of needles. The action plan proposes to reduce the re-use and sharing of needles among these individuals by promoting safer injecting. However, this may encourage these individuals to continue injecting and thus make the process of recovery more difficult.

Source 24	**Reducing Harm and Promoting Recovery: A Report on Methadone Treatment for Substance Misuse in Scotland**
Author(s)	Scottish Advisory Committee on Drug Misuse: Methadone Project Group; Scottish Government
Year	2007
Format/Availability	PDF
Type of Paper	Advice for formulation of government policy
Purpose of Paper	'To advise ministers on the place of methadone in the treatment of substance misuse in Scotland'.
Original Data	Partial
Evidence Quality	Mainly expert opinion with a small amount of evidence from a survey issued to all Scottish drug treatment services.
Intervention	Methadone for opiate dependent problem drug users.
Effect	Methadone maintenance treatment is more cost effective in terms of harm reduction than any other treatment for opiate dependency but should be delivered as part of a package of treatment to encourage both harm reduction and enhance recovery. Methadone treatment in Scotland can be optimised through improving accountability, performance management, information quality, effectiveness, integration and commissioning processes.
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Recommendations on providing effective interventions with methadone. Effectiveness of abstinence treatment: different results in England and Scotland (NTORS and DORIS) implying need for further research.
Relevance to Recovery (Individual)	Recommendation that methadone should be prescribed in the context of a care plan; recovery outcomes are improved when methadone is accompanied by wraparound services.
Relevance to Recovery (Service)	Current monitoring and evaluation data is sparse; services find it hard to extract data to undertake reviews, outcomes are rarely measured. More structured performance management systems in place to measure outcomes. Recommends medical interventions: a) replacement prescribing b) detoxification c) psychiatric. Recommends non-medical interventions: a) care planning, practical support, counselling and psychological interventions b) day care and community based rehabilitation c) residential rehab (little evidence).
Relevance to Recovery (System)	Further assistance with regard to outcomes monitoring and assessment, support for service review. Lack of available services in some areas means that methadone may be used as a standalone treatment. Lack of definite evidence around how many people receive methadone and how many achieve abstinence and/or recovery. Concern regarding child welfare and safety (although this may be improved by improved data collection questions). Optimisation of systems of care by delivery through integrated services and good governance, including training and supervision of staff, quality assurance and audit. Further research into treatment effectiveness and methadone effectiveness; better monitoring and evaluation is required - only 5 of 14 geographical health

	boards were able to supply information regarding methadone prescribing. Improved accountability and performance management for ADATs, through SG and national treatment body. Improved service effectiveness through shift in philosophy, review of resource management, clarifying expectations of treatment
GAPS/IMPLICATIONS/QUESTIONS	▪ Substitute prescribing with methadone has been judged on a narrow set of criteria for success. ▪ Some of the data regarding achieving abstinence varies between Scotland and England (NTORS and DORIS studies) implying areas for further research as to the effect of methadone plus other services. ▪ How does methadone support recovery, particularly if the only contact with services is prescribing? ▪ How can this be measured? ▪ Does not address the issue of recovery for people who are addicted to non-opiates

Source 25	**Report of the Stocktake of Alcohol and Drug Action Teams**
Author(s)	Scottish Government
Year	2007
Format/Availability	PDF
Type of Paper	Evaluation
Purpose of Paper	To guide Ministers when making decisions about the future role and form of ADATs.
Original Data	Interviews with staff and stakeholders of ADATs across Scotland
Evidence Quality	Working Group examination of role of ADATs based on semi-structured interviews undertaken with staff members of 22 ADATs.
Intervention	Effectiveness of ADATs; current performance and future capability to deliver Ministerial policy and priorities.
Effect	Partnership approach is the best one to tackle the problems of substance misuse in Scotland. This can be delivered effectively in the form of an ADAT provided that they fulfil certain criteria covering remit, composition and structure, performance and accountability, integrated and consistent approaches, resources and capacity building.
Sample size	22 ADAT areas.
Relevance to Scotland/ Technology transfer issues	Evaluation of role and structure of ADATs.
Relevance to Recovery (Individual)	Idea of an ADAT chimes with recovery as a holistic model; service users accessing a range of different services, which according to mental health literature, can be beneficial in terms of their recovery trajectory. Little evidence of the inclusion of service users' views in needs assessment/strategy/commissioning process; likewise little evidence of ADATs consulting with families and carers.
Relevance to Recovery (Service)	Better joint working and partnership working may be important in preventing service users falling through the gaps. Strategy based on equal dialogue with all the partners could potentially improve recovery outcomes. Current performance management and monitoring work is poor and more support for ADATs is needed in this arena - what therefore are the implications for designing and promoting outcomes based on recovery criteria?
Relevance to Recovery (System)	No mention of recovery in the document.
GAPS/IMPLICATIONS/QUESTIONS	▪ How can the partnership evolve to reflect the ethos of recovery i.e. Does a particular ADP structure support recovery better than another? ▪ How could ADPs build a focus on recovery into needs assessment, strategy, resource allocation, commissioning, contracting and performance management. ▪ No mention of recovery in the entire document. Suggests at the time of writing that this was not a strategic priority (previous administration).

Source 26	Essential Care: A Report on the Approach Required to Maximise Opportunity for Recovery from Problem Substance Use in Scotland
Author(s)	Scottish Advisory Committee on Drug Misuse: Integrated Care Project Group: Essential Care Working Group; Scottish Government
Year	2008
Format/Availability	PDF
Type of Paper	Advice for formulation of government policy
Purpose of Paper	To address the additional non-medical aspects of service required to ensure that people with substance use problems are given every opportunity to recover from their problems.
Original Data	No
Evidence Quality	Working group
Intervention	Essential services/key aspects of service provision which address an individual's physical, psychological and social functioning.
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Consideration of services required to maximise care, treatment and recovery alongside medical/clinical interventions
Relevance to Recovery (Individual)	In order for recovery to take place, a range of essential treatment services are required. Service users should be involved in service design and should be able to manage their own treatment. Services which will impact upon recovery are: Health improvement related to lifestyle (e.g. nutrition, exercise), life circumstances (unemployment, poverty) and inequality will contribute to recovery. Crisis management - better out of hours provision (most crisis episodes occur in people already known to services) General medical services including primary care providing services and dovetailing with substance misuse services. Integration of wider health service provision including BBV services, dental health and psychological services with substance misuse services.
Relevance to Recovery (Service)	Recovery must be the focus of services. Person-centred approaches are vital. Services must be run in accordance to principles of equality. Services must be accessible and offer a range of treatment options. Commissioners should undertake needs assessments; publish a written service specification; demonstrate service user involvement; collect data; report on outcomes. Substance abuse services should be available locally and regionally with other non-substance abuse specific services available in tandem. Services which could enhance recovery are: Health improvement, crisis management, primary care, BBV services, dental health. Each NHS Board area should develop a psychological therapies framework. Management of pregnant women with substance abuse

	problems must attempt to address addiction, health and social needs. Health and social care services should work jointly and with local authorities and the voluntary sector, employers, educational institutions and advice agencies to provide support in a range of areas. Specialist advice and advocacy services for people experiencing substance misuse problems would be advantageous.
Relevance to Recovery (System)	The report adopts a recovery ethos as its basis and affirms the need for service users to access a range of services in order for recovery to take place.
GAPS/IMPLICATIONS/QUESTIONS	The report acknowledges a lack of 'objective evidence to support this approach in the field of substance misuse' but argues that the comparisons with the field of mental health (CSIP common purpose) are sufficient to suggest that recovery would be meaningful in a substance misuse context. It references the Scottish Recovery Network as evidence that recovery is possible, specifically the idea that narratives of recovery can provide hope. Other evidence which is lacking includes detailed information regarding how successful the programmes in place are at achieving a reduction in drug related harm and promoting recovery. Lack of detailed information on staff expectations of service users - mental health studies argue that where clinicians are more hopeful for recovery for their patients, outcomes are improved. What should the new outcomes for measuring success be? How should services seek to record these and to whom will they be accountable? Lack of evidence around whether some wraparound services have a greater impact than others.

Source 27	**Concordat between the Scottish Government and CoSLA**
Author(s)	Scottish Government and CoSLA
Year	2007
Format/Availability	PDF
Type of Paper	Draft guidance to ADPs on operating in an outcomes environment.
Purpose of Paper	To enable Alcohol and Drug Partnerships (ADPs) to identify local priority outcomes related to alcohol and drugs.
Original Data	No
Evidence Quality	No original data
Intervention	To identify drug and alcohol outcomes that contribute to the achievement of national outcomes that address economic potential; young people are successful learners; children get the best start in life; longer, healthier lives; tackled inequalities; improved life chances of those at risk; lives safe from crime, danger and disorder; strong, resilient communities; in addition to the two specific National Indicators – reduce alcohol related hospital admissions by 2011 and decrease the number of problem drug users in Scotland by 2011.
Effect	Intermediate outcomes include attempts to link service delivery factors to local communities.
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	Switch to a strengths based model included – 'services should, as far as possible, focus on service users' strengths, promote recovery and integrate their aspirations into the service users' own plans for the future. Services should focus on service users' choice, even when they are subject to 'coercive' treatment'.
Relevance to Recovery (Service)	Attempts to link service delivery outcomes to recovery; children affected by parental substance misuse; enforcement and availability and prevention. Services should promote self-management, development of meaningful relationships and participation in positive activities.
Relevance to Recovery (System)	Aim is to 'identify and show the positive impact on communities, families and individuals that supporting drug and alcohol services delivers and the link this has with high-level and national outcomes'.
GAPS/IMPLICATIONS/QUESTIONS	High level outcomes related to alcohol and drugs make limited reference to recovery (point 57) and are linked primarily to 'safer and happier families and communities', with the primary focus on reductions in consumption and harms, and increased access to supports.

Source 28	Report of the Alcohol and Drug Delivery Reform Group
Author(s)	Alcohol and Drug Delivery Reform Group
Year	2008
Format/Availability	PDF
Type of Paper	Report of the Alcohol and Drugs Delivery Reform Group
Purpose of Paper	Recommendations to Government on future local partnership arrangements to tackle drug and alcohol use.
Original Data	No – based on some workshops but no data presented.
Evidence Quality	Not applicable
Intervention	'Our goal is to create an environment for the delivery of client-centred actions that achieve lasting change in the lives of individuals across Scotland, be they substance misusers, their families, or members of the communities in which they live'.
Effect	Not applicable
Sample size	Not applicable
Relevance to Scotland/ Technology transfer issues	Specific to Scotland
Relevance to Recovery (Individual)	As part of the process of implementation of *The Road to Recovery* and the focus on local measured needs.
Relevance to Recovery (Service)	As part of the process of implementation of *The Road to Recovery* and the focus on local measured needs.
Relevance to Recovery (System)	Accountability to be based at local level on National Performance Framework, Single Outcome Agreements and community planning, and NHS performance management arrangements including HEAT. Each local authority and NHS Board should develop strategies based on assessment of local need, identify key outcomes based on Single Outcome Agreements, and a broad outline of the services to be provided and commissioned. This is to be based on Alcohol and Drug Partnerships, supported by the Outcomes Toolkit and support coordinators.
GAPS/IMPLICATIONS/QUESTIONS	The key question will be how this approach will contribute to recovery-oriented systems of care.

Appendix 2: Independent Funding Sources

Source name: Medical Research Council
Website: http://www.mrc.ac.uk/index.htm
Organisation's purpose:
To improve human health through world-class medical research. Part of the MRC's strategic plan for 2009-2014 is to "aim to develop new approaches to tackle addiction, substance abuse and non-addictive alcohol use". The plan also states that "In addiction research, we will strive for increased coordination and connectivity across existing groups, and innovative, cross-disciplinary studies. Interaction of genetics with lifestyle will be studied in addictions, including smoking and alcohol."
How does it allocate funding:
Funding comes from the UK government. ▪ There are 12 grant programmes which relate to different types of research, such as long term programmes, joint research or research to improve methodology – the full list can be found at http://www.mrc.ac.uk/Fundingopportunities/Grants/index.htm ▪ There are different deadlines for all the different types of grants. For the main Research Grants scheme, research is divided into 4 areas and each area has 3 deadlines for applications a year, usually in January, April and September. ▪ Calls for Proposals – calls for applications for funding to stimulate research in pre-determined areas are made throughout the year. ▪ Fellowships – funding for researchers for a fixed term, for example 5 years, and sometimes for a particular area of research, or funding to an organisation to allow them to run a fellowship programme. Most are annual competitions, such as Methodology Research Fellowships. ▪ Studentships – funding for postgraduate study. Student applies through their educational institution. Applications for funding are done in rounds, either every year or every few years.
What type of project does it fund:
Research grants and career awards to scientists in UK universities and hospitals and research centres in partnership with universities. The MRC also has its own research facilities. In 2008/09, the MRC spent £704.2 million on research.
What projects is it currently funding in the area of substance misuse, addiction and recovery:
The Medical Research Council (MRC) is leading a strategy for addiction research in partnership with other organisations which has 3 funding parts: 1. 'Pilot grants' to fund research that makes better use of existing resources. This call is closed and nine awards, worth £1.95 million, were made.

2. Initial seed corn funding to develop interdisciplinary addiction research clusters with the objective of supporting networking, building research capacity, importing new expertise and increasing co-ordination. This call is closed and eleven awards were made in July 2009.
3. A ring-fenced call open only to those addiction research clusters established through the second call. It will be interdisciplinary research leading to new approaches to tackling the harms caused by illicit drugs, alcohol, tobacco and gambling. Launched in 2010, it has a budget of £4.5 million.
Further information on their addiction research strategy can be found at http://www.mrc.ac.uk/Fundingopportunities/Initiatives/Addictionresearch/index.htm

Source name: National Institute of Health Research

Website: http://www.nihr.ac.uk/Pages/default.aspx

Organisation's purpose:

The National Institute for Health Research is now established as a part of the UK Government's strategy, 'Best Research for Best Health'. It works with the UK Government in aiming to establish the NHS as an internationally recognised centre of research excellence through supporting outstanding individuals, working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public.

How does it allocate funding:

- There are 8 NIHR run programmes, such as Research for Patient Benefit and Service Delivery and Organisation, which commission and fund research. There are also 5 programmes that it is involved in running jointly with the MRC.
- It has created and given money to 'Schools' (joint ventures between academic institutions) for research into Primary Care and Social Care.
- It has also created Research Units for particular topics.
- It issues calls for research proposals and each area of research has an implementation plan with timetables for accepting applications in that area.

What type of project does it fund:

NIHR commissions and funds NHS and social care research that it considers to be essential for delivering responsibilities in public health and personal social services.

What projects is it currently funding in the area of substance misuse, addiction and recovery:

- The Public Health Research Programme has been created to fund both primary research and evidence synthesis, depending on the availability of existing research and the most appropriate way of responding to important knowledge gaps.
- The funding available for the Public Health Research Programme was up to £2m in 2008/9, rising to £5m in 2009/10 and £10m in 2010/11
- None of its current projects relate to addiction, substance misuse or recovery
- However, it is currently looking for proposals on research into the relationship between reduction in alcohol availability and measures of community alcohol health related harm and/or consumption.

Source name: Chief Scientist's Office

Website: http://www.cso.scot.nhs.uk/

Organisation's purpose:

The CSO supports and promotes high quality research aimed at improving the quality and cost-effectiveness of services offered by NHS Scotland and securing lasting improvements to the health of the people of Scotland

How does it allocate funding:

- Project Grants and small grants can be applied for. The CSO funds up to 80% of the cost of a project up to a maximum of £225000 for Project Grants and £50000 for Small Grants
- Programme Grants for mental health and cancer research are funded up to £450000
- Applications are submitted to committee for consideration, with 3 rounds of funding per year
- The Health Services Research Committee is one of the two committees who assess applications
- Postgraduate studentships and doctoral and postdoctoral fellowships are awarded each year

What type of project does it fund:

It funds fund projects in 5 areas: Cancer, Cardiovascular disease and stroke, Mental health, Public Health and NHS needs

What projects is it currently funding in the area substance misuse, addiction and recovery:

In 2008 the Edinburgh Addiction Cohort project was accepted as completed.

In 2007-08 awards were made for projects entitled "Feasibility study for a further data collection sweep for the Drug Outcomes Research In Scotland (DORIS) study", "Life course predictors and consequences of injecting drug use: a population-based case-control study", "A cluster randomised controlled trial of enhanced pharmacy services for methadone patients" and "Management of drug misuse in primary care: a seven-year follow-up survey of Scottish general practitioners" – from CSO's Annual Report 2007-08, accessed at http://www.scotland.gov.uk/Resource/Doc/257049/0076314.pdf

None of the current fellowships or studentships are in the substance misuse, addiction and recovery field.

Source name: European Union – CORDIS

Website: http://cordis.europa.eu/home_en.html

Organisation's purpose:

Through Framework Programme 7, which runs from 2007-2013, the EU will fund research to strengthen the scientific and technological base of European industry and to encourage international competitiveness while promoting research that supports EU policies

How does it allocate funding:

Mainly through calls for proposals which are published in the EU journal and CORDIS website.
Over period 2007-2013 there are 48.71 billion Euros to distribute in all 4 streams.

What type of project does it fund:

Four main themes

- Co-ordination – encouraging transnational collaboration
- Ideas – research in a specific area – implemented by a European Research Council which awards grants
- People – fellowship type sponsorship
- Capacities – relates to research infrastructure

What projects is it currently funding in the area substance misuse, addiction and recovery:

Calls for proposals on the general Health topic were closed in October and November 2009.

Calls for different levels of European Research Council grants have deadlines throughout the year.

A basic search of database showed up only one project from last 4 years that is in the field of alcohol or substance misuse (*Tobacco, Alcohol and the risk of UADT Cancers*, published 2006)

Source name: Wellcome Trust

Website: http://www.wellcome.ac.uk/index.htm

Organisation's purpose:

The Wellcome Trust is dedicated to achieving extraordinary improvements in human and animal health and aims to support the brightest minds in biomedical research and the medical humanities

How does it allocate funding:

- Research Fellowships – consider applications usually once or twice a year but some are open for applications all the time
- Grants – deadlines staggered throughout the year for different types of grants but some are open all the time
- Capital Funding of over £1 million has ad hoc calls for applications, lesser awards have yearly application process

What type of project does it fund:

- Biomedical Science
- Technology Transfer
- Medical Humanities
- Public Engagement

What projects is it currently funding in the area substance misuse, addiction and recovery:

In their most recent annual record for awarding of grants from 1st October 2008 – 30th September 2009 the projects relating to this field which received grants were

- "Scottish Inebriate Reformatories, 1901-1925: The medical role in the response to the last alcohol epidemic",
- "Motivational ambivalence and alcohol abuse"
- The 5th International conference on the history of drugs and alcohol: Pathways to prohibition' held at the University of Strathclyde was also given funding.

Source name: Robertson Trust

Website: http://www.therobertsontrust.org.uk/

Organisation's purpose:

An independent Scottish trust that makes grants to charities

How does it allocate funding:

The Robertson Trust no longer funds research in this field but will consider supporting community based projects with a research component, where service delivery is the primary focus.

In the year to March 2009 the Trust committed £9.9 million to 497 different charities. These donations will be paid out over the next three years.

- Small and main donations form the bulk of the donations made by the Trust and are assessed on a rolling programme with recommendations made to the Trustees six times a year.
- Major capital donations where the total value is in excess of £1M will be considered three times a year in January, May and September.
- Development Awards are for special category of research areas where the Trust identifies partners with whom they can develop new initiatives. This is always ongoing.

What type of project does it fund:

The Trust has 4 priority areas:

- Care
- Health
- Education and Training
- Community Art and Sport

There are 7 other categories that they will support which are:

- Animal Welfare
- Civil Society
- Communities
- Culture
- Heritage and Science
- Environment
- Saving Lives
- Young People and Families

The Trust is most interested in funding direct service delivery to people in Scotland in need of this support

They do not fund medical research or organisations and projects whose primary object is to provide a counselling, advocacy, advice and/or information service

What projects is it currently funding in the area substance misuse, addiction and recovery:
▪ Drug and Alcohol Misuse is one of the areas where there have been development awards. One of these was for research and one was in relation to early intervention support to children living in drug using families with two further awards in the pipeline. They are looking to develop further partnerships in this area with charities involved with alcohol misuse, particularly with an innovative approach to prevention issues ▪ The Annual Review of 2008/09 also mentioned a donation to Mentor UK to enable them to develop their work in Scotland supporting community-based organisations to develop activities to address issues of alcohol misuse with young people.

Source name: Joseph Rowntree Foundation

Website: http://www.jrf.org.uk/

Organisation's purpose:

The Foundation is an endowed charity that funds a large, UK-wide research and development programme. It seeks to understand the root causes of social problems, to identify ways of overcoming them, and to show how social needs can be met in practice.

How does it allocate funding:

Research is funded solely through calls for proposals in specific areas

What type of project does it fund:

The Foundation has an alcohol theme which aims to support research and other work in order to have an impact on negative drinking cultures and patterns among young people in the UK.

What projects is it currently funding in the area substance misuse, addiction and recovery:

During last 2 years the Foundation has published a number of reports in the field of substance misuse;

- Children, young people and alcohol: how they learn and how to prevent excessive use
- Tackling alcohol harm: lessons from other fields
- Drinking in the UK: An exploration of trends
- Guidance on standards for the establishment and operation of drug consumption rooms in the UK
- Street policing of problem drug users
- Cannabis supply and young people

Alcohol is one of their chosen themes for research; another is entitled 'Social Evils' in which drugs and alcohol were also raised as an issue. The project involved a consultation process and has resulted in a book, *Contemporary Social Evils*.

Source name: Lloyds TSB Foundation for Scotland

Website: www.ltsbfoundationforscotland.org.uk

Organisation's purpose:

The Foundation distributes its funds to recognised charities in Scotland which are focused on improving the quality of life and creating equality of opportunity for people in Scotland. This applies particularly to those who are disadvantaged and marginalised, with particular emphasis on grassroots charities, and organisations which help those most in need become self-sufficient or improve the quality of their lives.

How does it allocate funding:

- Standard Grant scheme – 6 deadlines per year
- Capacity Building grants – designed to help organisations run as effectively as they can by working with them to identify strengths and set out opportunities for development. Applications can be made at any time of year

Awards are made in February, April, June, August, October and December.

What type of project does it fund:

- Research – for example, grant to Royal Society of Edinburgh in 2008 to research issues relating to the ageing population.
- Salary Costs – the Foundation contributes to salaries for charities' staff from development workers to Chief Executives
- Capacity Building – grant to pay for consultancy on governance or business planning and strategy, for example Tayside Council of Alcohol in December 2009 round of awards
- Staff Training – for example, Monklands Women's Aid were given money for staff to get SVQs in December 2009 round of awards
- Running Costs or equipment – for example, minibus costs or hall hire

What projects is it currently funding in the area substance misuse, addiction and recovery:

Partnership Drugs Initiative - Since 2000 the Foundation has been funding this initiative along with the Scottish Government. It promotes voluntary sector work with vulnerable children and young people affected by substance misuse. To date it has distributed £13 million.

Source name: Cross-Governmental Research Programme on Drugs

Website: http://drugs.homeoffice.gov.uk/ (most information comes from document "The Cross-Government Drugs Research Strategy (2010) found at http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/cross-gov-drugs-resech-strategy2835.pdf?view=Binary)

Organisation's purpose:

Created in 2008 as part of a review of overall UK Government drug strategy in England. The objective of the programme is to "provide the foundation, direction and guidance for collaboration within government, and between government and other stakeholders, in the development of a robust scientific evidence base for government drug policy in the short and long term".

How does it allocate funding:

The programme does not itself fund research but aims to co-ordinate and guide the funding of projects by individual UK government departments in the field

The CGRPD will assess research annually, including monitoring its delivery, and assess what research is needed to fulfil the aims of the drug strategy. It will continuously review the research priorities and change them if necessary. For the purposes of assessing needs and reviewing priorities it will also consider research done outside of government, such as that funded by the Medical Research Council or Economic and Social Research Council

What type of project does it fund:

The priorities for their research strategy are

- To strengthen our understanding of drug use: aetiology, incidence, prevalence and patterns of use in the population.
- To further strengthen our knowledge of drug use and needs amongst a number of groups, including young people, black and minority ethnic (BME) groups, families, and drug-using offenders.
- To review our knowledge and measures of drug-related harms.
- To develop our understanding of treatment, prevention, and other interventions.
- To review and strengthen understanding of UK drug markets, and interventions to tackle them.
- To strengthen our understanding of public confidence, perceptions, and behaviour.

What projects is it currently funding in the area substance misuse, addiction and recovery:

The programme does not directly fund research, but has set out key UK Government research priorities in the drugs misuse field.

ISSN 0950 2254
ISBN 978 0 7559 9505 9
web only publication

www.scotland.gov.uk/socialresearch

APS Group Scotland
DPPAS10403 144621 (07/2010)

GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

ISBN: 978-0-7559-9505-9
9 780755 995059



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Ali, S. (2010). Lapse and relapse: Is it time for a new language. Posted at **www.williamwhitepapers.com**

Lapse and Relapse: Is it time for new language?

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A new addiction recovery advocacy movement in the United States is challenging many of the concepts and terms that have historically portrayed alcohol and other drug (AOD) problems (Ali, 2010; Kelly, 2004; Substance Use Disorders, 2004; White, 2006, 2007a). Recovery advocates contend that language has been an important tool in the stigmatization, demedicalization, and criminalization of AOD problems and the marginalization of people affected by these problems (White, 2007b). Recovery advocates are calling attention to new research studies that confirm these effects (Kelly, Dow, & Westerhoff, in press; Kelly & Westerhoff, 2010).

The authors have been part of these extended debates about language in the addiction, treatment, and recovery arenas. In this essay, we discuss two words—*lapse* and *relapse*—that we argue are rooted in moral and religious conceptions of AOD problems and should be replaced with terms that are morally neutral and precise and that more aptly depict the processes involved in the experiences of people with AOD problems who resume AOD use following voluntary periods of sobriety.

Origin and Moral Meanings

The addictions field has long used the term *relapse* to describe a return to drinking or drug use following a period of voluntary abstinence by those who have a history of AOD-related problems. The field has more recently attempted to distinguish *lapse* or *slip* (a brief episode of AOD use) from *relapse* (the resumption of more extended and excessive AOD use involving the return of symptoms meeting diagnostic criteria for a substance use disorder). Rates of lapse and relapse are difficult to compare across studies due to different definitions of these terms (Maisto, Pollack, Cornelius, Lynch, & Martin, 2003; McKay, Franklin, Patapis, & Lynch, 2006; Simonelli, 2005).

The *lapse/relapse* terms are rooted in morality and religion, not health and medicine, and come with considerable historical baggage. The early and contemporary meanings of these terms include:

- abandonment of religious faith, e.g., lapsed Catholic,
- moral failing, e.g., lapse in grace, wrongdoing, violation of a moral standard,
- neglect of one's personal or social responsibilities, e.g., lapse in insurance coverage or membership due to failure to make payment,
- return of slovenly character, e.g., lapse into bad habits,
- deviation from accepted standards as a result of carelessness, negligence or lack of effort, e.g., lapse in judgment,
- deterioration in discipline or ability, e.g., lapse in memory, and
- fall, fail, regress, backslide, descend, revert.

These terms entered medicine at a time health conditions were thought to be inextricably linked to a person's religious or moral conduct. The onset and recurrence of many complex health problems were once shrouded in shame because of such associations. The implied moral connections between the relapse of tuberculosis, cancer, epilepsy and schizophrenia slowly faded as the etiology and course of these disorders became more clearly understood.

In the alcohol and drug problems arena, the lapse/relapse language emerged during the temperance movement to refer to individuals who had returned to drinking after publicly signing a temperance pledge. "Falling off the water wagon" was linked in the public mind to lying, deceit, and low moral character and was viewed as a product of badness rather than sickness (White, 1998). The moral overtones created by the *lapse/relapse* language shaped broader communications in which those who were drug free were referred to as *clean* while people who were using drugs were viewed as *dirty*. The moral roots of *lapse/relapse* are further illustrated in the synonyms for *clean* (e.g., pure, unblemished, faultless, flawless, good, innocent, sinless) and for *dirty* (e.g., stained, tainted, polluted, infected, defiled, foul, filthy, immoral, lewd, vile, vulgar).

The Scope of Application of Lapse/Relapse

Internet search technologies provide a way to investigate the frequency at which two terms are associated. Table 1 reveals the frequency with which references to lapse and relapse appear in conjunction with various terms used to convey the presence of alcohol- or other drug-related problems. It can be seen that this pairing is most frequent in reference to the terms alcoholism and addiction. It is noteworthy that references to *lapse* and *relapse*—terms associated with moral choice—rise when paired with the term *abuse*—another term that conveys a person of contemptible character. (Note in Table 1 how references to *lapse* and *relapse* increase in the shift from *alcohol dependence* to *alcohol abuse*.) The *lapse/relapse* terms combined with references to *abuse* convey a greater sense of personal culpability, and as recent research reveals in the case of the *abuse* language, elicits more punitive attitudes (Kelly et al., in press; Kelly & Westerhoff, 2010).

To compare the pervasiveness of the link between *lapse/relapse* and AOD problems, we compared these references to those for the link between these same search terms and the word *recovery*. It can be seen from Table 1 that the terms *lapse* and *relapse* are as pervasively linked to AOD problems as is the term *recovery*.

Table 1: Number of Internet Lapse/Relapse References Linked to Terms used to Depict Alcohol and other Drug Problems (Google Advanced Search on February 8, 2010)

AOD-related Disorder	Number of Internet Lapse References	Number of Internet Relapse References	Total Lapse / Relapse References	Number of Internet Recovery References
Alcoholism	11,200,000	8,490,000	19,690,000	2,610,000
Alcohol Addiction	8,930	121,000	129,930	465,000
Alcohol Dependence	43,600	142,000	185,600	159,000
Alcohol Abuse	97,800	622,000	719,800	890,000
Addiction	520,000	1,490,000	2,010,000	2,290,000
Drug Addiction	161,000	484,000	645,000	1,390,000
Drug Dependence	11,000	131,000	142,000	282,000
Drug Abuse	762,000	130,000	892,000	2,000,000

To compare the application of the *lapse/relapse* terms to alcohol and other drug problems and other chronic medical disorders, a similar search was done on the pairing of references to *lapse/relapse* with other chronic disorders. Table 2 reveals the wide application of the terms *lapse/relapse* to other medical and behavioral health conditions. This would seem to indicate the medical legitimacy of these terms, but three points challenge such a conclusion. First, many of the conditions listed contained moral overtones during earlier historical periods, and continued use of the *lapse/relapse* language may reflect such residual effects. Second, the term *relapse* is being abandoned in fields such as cancer treatment for more medically precise and morally neutral terms, e.g., *recurrence*. Third, *lapse* and *relapse* are not applied to these conditions nearly as frequently as they are to AOD problems. The terms *lapse* and *relapse* are applied to alcoholism more than to any other single medical condition listed in Table 2.

Table 2: Number of Internet Lapse/Relapse References Linked to other Chronic Disorders (Google Advanced Search on February 8, 2010)

Chronic Health Disorder	Number of Internet Lapse References	Number of Internet Relapse References	Total Lapse / Relapse References
Diabetes	506,000	8,060,000	8,566,000
Type I Diabetes	31,600	147,000	178,600
Type 2 Diabetes	45,000	182,000	227,000
Cancer	1,500,000	3,020,000	4,520,000
Tuberculosis	1,300,000	3,910,000	5,210,000
Hypertension	1,600,000	4,910,000	6,510,000
Epilepsy	1,740,000	3,220,000	4,960,000
Asthma	2,850,000	4,990,000	7,840,000
Depression	1,220,000	2,010,000	3,230,000
Schizophrenia	118,000	5,330,000	5,448,000
Mental Illness	216,000	702,000	918,000
AIDS	887,000	955,000	1,842,000

The applications of the terms *lapse* and *relapse* are by no means restricted to medical conditions. Table 3 illustrates the widespread application of these terms to a spectrum of immoral and criminal behaviors.

Table 3: Number of Internet Lapse/Relapse References by Immoral or Criminal Behavior (Google Advanced Search on February 8, 2010)

Immoral or Criminal Behavior	Number of Internet Lapse References	Number of Internet Relapse References	Total Lapse / Relapse References
Adultery	1,480,000	595,000	2,075,000
Lying	1,180,000	4,460,000	5,640,000
Assault	672,000	4,260,000	4,932,000
Rape	304,000	3,420,000	3,724,000
Murder	941,000	5,340,000	6,281,000

Table 3 illustrates the close connection between the terms *lapse* and *relapse* and immoral and criminal conduct. It is noteworthy that these terms are as likely to be linked to lying or murder as they are to cancer, tuberculosis, epilepsy, AIDS, or schizophrenia. The blurring of the boundary between the language of moral judgment and the language of medical diagnosis and treatment raises important questions about the use of terms such as *lapse* and *relapse* in addiction treatment and recovery support contexts.

Miller's Early Critique of Relapse

In 1996, William Miller challenged the addiction field's use of the *relapse* concept/term. Miller argued that the relapse concept/term:

- suffers from definitions that are ambiguous, variable, and arbitrary,
- presents outcomes in a binary classification of complete success (perfect abstinence) or complete failure (any AOD use) without reference to threshold (amount of AOD use), window (span of time being judged), reset (period of abstinence preceding AOD use), polydrugs (range of drugs used that would constitute a relapse), consequences (use versus problems resulting from use), and verification (methods other than self-report to verify AOD use or non-use),
- imbues judgment and shame on complex addictive behaviors that are more likely to be changed incrementally over time than through transformational change experiences that are sudden, unplanned, and permanent (Miller & C'de Baca, 2001),
- may elicit the very behaviors it seeks to prevent via self-fulfilling prophecy ("one drink-one drunk")—what Marlatt (1996) christened the "abstinence violation effect" (demoralization that results in forsaking recovery efforts and escalation of AOD use), and
- equates health (recovery) with the absence of pathology rather than global measures of health and functioning.

Miller concluded: "…it may be useful, for both clinical and research applications, to abandon the term 'relapse' and focus instead on concepts and models that are more descriptive of the normal course of human behavior change" (Miller, 1996, p. S26). It is our intent in this essay to revive and extend Miller's discussion and recommendation.

Lapse/Relapse: Health Condition or Moral Choice?

The way that we as a culture and as service professionals talk about and perceive people with AOD problems affects how we care for them and whether or not we are willing to invest in

helping them find long-term recovery. It makes a difference if they are perceived as having a legitimate health condition requiring medical care or perceived as sinful or recalcitrant misfits and criminals. If AOD problems are seen as the consequence of a brain disease that erodes volitional control over AOD-taking decisions, people seeking recovery will be deemed worthy of care and support. If people seeking recovery are viewed as moral agents who have failed to exercise full volitional control over their decisions, they will be viewed as deserving punishment for their perceived refusal to stop using alcohol and other drugs. If post-treatment AOD use decisions can be profoundly influenced by changes in the neural circuitry of the brain—as suggested by recent scientific studies (e.g., see review by McKay and colleagues, 2006)— then exclusively moral or characterological depictions of AOD-use decision-making need to be seriously re-evaluated if not discarded.

The moral overtones imbedded within the *lapse/relapse* terms are manifested in the following ways addiction treatment programs have responded to persons using AOD after the initiation of professional treatment.

1. They may be administratively discharged (also called disciplinary discharge or therapeutic discharge) for becoming symptomatic during their care—making addiction treatment the only arena of health care where a patient can be thrown out of treatment for exhibiting a symptom of the condition being treated.
2. If they return to treatment, they may be punished (refused admission without a firm referral to other treatment) on the grounds that they had their chance (and blew it!). They may also be told that further treatment in this setting would be counterproductive for them and demoralizing to people receiving care for the first time. Such policies would be unthinkable for other health conditions. In the medical treatment of other health problems, a treatment that does not result in symptom alleviation is followed by adjustments in the treatment or different treatment, not punishment of the patient.
3. They may be subjected to arbitrary time periods that must pass before they will be considered for re-admission, a requirement unthinkable in other health care settings.
4. They may be required to commit to a longer (and more life-disrupting) period of treatment, although it may be the same type of treatment previously received. This suggests that the responsibility for post-treatment resumption of AOD use is a personal failure and not the failure of the treatment provided or the lack of post-treatment support.
5. People returning to treatment are often subjected to a variety of shaming rituals as a condition of re-entry. As a result, when people who resume AOD use following their discharge from treatment are asked why it took them so long to return to treatment, their answers resound with the theme of shame.
6. People re-entering addiction treatment are subjected to pejorative labels that lower staff expectations related to their long-term recovery outcomes. Terms like *retread* and *frequent flyer* are all too common.

The effects of the term *relapse* extend far beyond the treatment environment. The moral judgment that has historically been attached to the term *relapse* sets the stage for disaffiliation (e.g., divorce, family estrangement, social shunning, job loss, loss of housing), disenfranchisement (e.g., loss of parental rights, denial of access to public benefits), and sequestration (e.g., violation of probation/parole and imprisonment). More recently, efforts to cast addiction as a “chronically relapsing disease” may inadvertently misrepresent recovery outcomes and create a “no-fault” condition, meaning that it is expected that people will resume using alcohol and drugs because that’s part of the condition. This perspective renders treatment programs and those seeking recovery “equally powerless to battle with the fates” (Brown, 1998, p. 2518; White & McLellan, 2008).

Event or Process?

Depicting addiction and recovery as binary states demarcated only by the initiation or cessation of AOD use is challenged by a growing body of research suggesting these states are more aptly described on a more graded continuum. In fact, it may be helpful to think of that continuum marked by three broad zones of action and experience: 1) a stage of excessive, compulsive, and problematic AOD use, 2) a stage of recovery stability, and 3) a transitional stage in which people pass back and forth between addiction and recovery. This third transitional stage is important in escaping the definition of lapse/relapse as a self-encapsulated behavioral event. Recognition of this broader continuum and its three stages acknowledges several key understandings and raises important questions.

- The earliest steps of the recovery process begin in active addiction, e.g., via destabilization of addiction and incremental steps towards the transition stage. What self, family, and professional intervention strategies could be utilized to speed the destabilization of addiction and movement into the transition zone?
- The act of alcohol or drug use following sustained abstinence is preceded by a destabilization of recovery and entrance into the transition zone—a period in which interventions could be targeted to re-stabilize recovery. Substantial work has been achieved on identifying the precursors to recovery destabilization (e.g., decreased self-efficacy, negative emotional states, isolation, negative social support, interpersonal conflict, traumatic distress, exposure to AOD-using environments).
- The transition zone represents more than the status of AOD use and encompasses broader changes in global health/distress—*global* here embracing the physical, cognitive, emotional, relational, occupational, and spiritual (broadly defined in terms of life meaning and purpose) aspects of one's life. What patterns of change within these dimensions typify the most common stages of long-term recovery and the recurrence of addiction? How can increases in recovery capital in these other areas be used to prime pro-recovery decisions related to AOD use?
- The transition zone is more than addiction but less than recovery. It is experienced as a war of conflicting needs and desires in which incongruent ideas, emotions, and behaviors co-exist—though with considerable disharmony, e.g., wanting to get high and also wanting to stop using, reading recovery literature or calling hotlines while intoxicated, making recovery support meetings but maintaining contact with using peers, and sustained emotional discomfort—both drug-free and drug-intoxicated. How can addiction ambivalence be increased to heighten motivation for recovery and recovery ambivalence decreased to reduce vulnerability for re-addiction?
- Entry and directional movement within the transition zone are marked by catalytic experiences that can move one toward recovery (e.g., transformational change experiences, participation in recovery mutual aid groups) or toward a reactivation of addiction (e.g., craving, selective memory, selective attention, emotional distress, exposure to drug cues) and are also marked by personal responses to those experiences (e.g., successful or failed coping strategies). How can recovery self-management skills be most effectively enhanced?

All of these understandings—many the product of existing *relapse prevention* research—call for a language that is process-focused rather than event-focused. While embedded in such a process, there remains what McKay and colleagues (2006) depict as a "moment of truth"—a decision that results in use or continued abstinence (and the further decisions that follow). This process of recovery erosion and that final act of crossing out of recovery back into active AOD

use needs greater illumination. We support the expansion of existing research on what has been christened *relapse*, but suggest that what is being studying warrants a more precise and morally neutral language.

Toward a Morally Neutral Language

Choosing words that work within the AOD problems arena is not easy. Such terms must work at many levels--personal, family, professional, social, and policy. The fact that a word choice often works at one level but not other levels produces constant tension to shift from one word or phrase to another. The debate continues because these words matter to the lives of affected individuals and families. They matter to the professionals charged with the care of these individuals and families, and they matter to industrial and community economies. Billions of dollars can be transferred from one industry to another and one community to another (with the concomitant rising and falling of professional careers) based on a shift in words that moves cultural ownership of AOD problems from one arena to another (e.g., from the criminal justice system to specialty sector addiction treatment, or vice versa; White, 2004).

The existing *lapse/relapse* language matters at all of these levels, and to some extent, this language has worked. References to *relapse* are commonly heard in any arena in which AOD problems are discussed. The term captures the essence of the problem with addiction—that the act of stopping AOD use is often not the end of the addiction story and is often a cyclical benchmark in prolonged addiction careers. *Relapse prevention* has been a core idea in the modern personal and professional management of addiction recovery (e.g., Marlatt & Gordon, 1985). The prevention of relapse has been a central goal in the design of exemplary programs ranging from drug courts to physician health programs. Given this evident utility, why should we change the lapse/relapse language?

The answer to this question, as we have suggested, is that the lapse/relapse language has harmful side-effects for affected individuals and families, for professional models of problem intervention, and for communities affected by AOD problems. The use of a morality-based language to depict the prolonged, cyclical course of substance use disorders misidentifies the essential etiology of these disorders (as a problem of moral character rather than brain disease), fails to look at contextual (e.g., treatment-related, environmental) factors that also influence in-treatment and post-treatment AOD use, and contributes to punitive rather than corrective approaches to long-term recovery management. We are not proposing that the functions and skills traditionally embraced within the rubric of relapse prevention be abandoned, but we are suggesting that these arena be rechristened with language that is more behaviorally precise and less personally stigmatizing.

So how do we depict the resumption of AOD use in a person who has committed himself or herself to sustained sobriety? Such a language should meet several key criteria.

First, it should help individuals, families, and professional helpers understand and label such events or processes and suggest future strategies for their prevention. What is needed is a medical language that has not been imbedded with the moral baggage contained in the words *lapse/relapse*. That term or phrase may not yet have been coined.

Second, the ideal language should encourage individuals experiencing AOD problems to assume personal responsibility for resolving these problems. The “slip” vernacular of Alcoholics Anonymous may not be ideal in that the term implies an accident over which one has no control. Considerable effort has been extended in AA to generate folk wisdom that places responsibility back on self, e.g., “If you don’t want to slip, stay away from slippery places,” “a slip is a premeditated drunk,” etc. The vernacular for relapse in Narcotics Anonymous reflected in the slogan “don’t pick up” places greater emphasis on drug use as a personal decision and act.

Third, the language should be capable of depicting the resumption of AOD use in the context of a larger process rather than an inexplicable act—more a process of drift than a

singular decision. The *lapse/relapse* language is event-focused rather than process-focused. The ideal replacement for *lapse/relapse* should convey the physical, cognitive, emotional, spiritual, and social processes that precede and trigger the act of resuming AOD use.

Fourth, while promoting personal responsibility and accountability, the language should also reflect an understanding that extra-personal factors (e.g., the family and social environment, the quality of particular treatment protocols) also influence post-treatment AOD use.

Fifth, the language should be able to distinguish levels of severity of symptom reactivation. The distinction between lapse and relapse seeks such a distinction but does so in less than ideal language.

Some Preliminary Recommendations

Language that meets the above criteria and that fully works at personal, family, professional, and community/cultural levels may not be possible, and will not be possible without sustained discussion and debate across multiple stakeholders. We have offered quite specific language recommendations in the past (White, 2001, 2002, 2004, 2006; White & Kelly, 2010), but our recommendations here are less clear. As a starting point for discussion, we offer some closing thoughts about the future of the lapse/relapse language within the addiction, addiction treatment, and recovery support arenas.

1. *Individuals and families who are seeking to resolve AOD problems should be encouraged to embrace or construct whatever language works for them (i.e., serves as a catalyst for positive change).* These sense-making and change-eliciting metaphors may differ across the stages of recovery, and they also differ markedly within and across cultural settings. The lapse/relapse choices may "work" for many until better language emerges without their unintended side effects.
2. *Recovery mutual aid groups and recovery community organizations may choose to use one set of words for intra-group communication to convey the resumption of AOD use and another set of words for communications to the public.* It has been our experience that language that works at a personal level for intra-group communication (e.g., use of the term *recovering* to depict recovery as a life-long process) may not work for extra-group communication (e.g., use of the term *recovered* to avoid the public interpreting *recovering* to mean that people never really recover from addiction). There may be multiple sets of language emerging to span this range of communication venues.
3. *Professional references to lapse and relapse and future alternatives to such terms should apply only to a return to AOD use and related problems AFTER evidence of stabilization of the substance use disorder.* We would propose that any AOD use before 90 days of voluntary cessation of AOD use in the community constitutes not a return of a substance use disorder, but a continuation of the disorder. The absence of AOD use in a controlled environment does not constitute evidence of such stabilization. In short, reactivation of a disorder cannot occur until the disorder has first been deactivated. Much of what in the addictions and related fields is characterized as lapse or relapse behavior actually constitutes continued symptoms of a disorder that has not been brought into stable remission. Similarly, brief episodes of abstinence often constitute brief respites in one's addiction career, not a milestone of recovery.
4. *The terms lapse and relapse should be dropped from the professional lexicon of the addictions field and be replaced by more morally neutral, behaviorally descriptive, and medically precise language*.
5. *The professional addictions field should embrace a person-centered, strengths-based language that focuses not on pathology but the reality and processes of long-term recovery*. We recommend that "relapse prevention programs" be reframed and

redesigned as “recovery support programs.” The focus should be more on what is being embraced rather than what is being avoided.

6. *In defining alternatives to lapse/relapse, the field should focus on language that embraces all dimensions of recovery rather than just the status of using or not using alcohol or other drugs*, e.g., terms like wellness, global health, quality of life, life meaning/purpose, community inclusion, and citizenship that capture broader dimensions of personal and social health.
7. *The common contention that “relapse is part of recovery” should be abandoned. Relapse is NOT part of recovery*. A resumption of alcohol and drug use is an expression of the disorder, not of the recovery process.
8. *In defining alternatives to lapse/relapse, the field should elevate language that focuses on recovery-supporting skills (e.g., resist, desist, refuse) rather than language that conveys a process of passively succumbing to AOD use.*

The table below illustrates possible alternatives to the lapse/relapse language.

Common Language	**Problem**	**Language Alternatives**
John *relapsed* after his discharge from addiction treatment.	Language implies moral failure.	John *resumed* (or *reinitiated*) drinking following his discharge from addiction treatment. John experienced a *recurrence* of his alcohol dependence four months after his discharge from addiction treatment.
John is a chronic *relapser*.	John ceases to be a person through such objectifying language. He becomes instead a “thing”—a category.	John is a person who has experienced recurring episodes of alcohol-related problems. John continues to experience intermittent episodes of substance use. John has not yet achieved stable recovery in the community.
John has *relapsed,* but things are not as bad as they used to be.	Language conveys degrees of John’s “badness.”	John is in *partial remission* from alcohol dependence. John continues to experience some alcohol-related problems, but he has reduced the frequency and intensity of his drinking.
John has not *relapsed* since his last treatment.	Focus is on what John has not done rather than what he has achieved.	John has maintained stable recovery. John’s alcohol dependence is currently in *full remission*. John is a person in long-term recovery: he has not used alcohol or other drugs

		since _____ (date)—or for _____ years (See Faces and Voices of Recovery, 2009).
John needs to go through a *relapse prevention* program/plan.	Relapse prevention is a negative framing of recovery—a focus on what behavior is to be eliminated from one's life rather than what is to be added, e.g., sickness prevention orientation versus health promotion orientation—the equivalent of a baseball hitting coach focusing on "strikeout prevention."	John could benefit from a program of sustained *recovery management* (or *recovery support*—strategic increases in personal, family, and community recovery capital). John needs a *recovery plan*. Focus is not on subtracting but adding three defining elements of recovery: sobriety, improvement in personal and family health, and positive connection to community (citizenship) (Betty Ford Institute Consensus Panel, 2007).
Relapse is part of recovery.	This normalizes the presence of pathology as a dimension of recovery. For persons with severe substance use disorders, AOD use is part of the disorder, NOT part of the healing process. (See earlier discussion of "Transition Zone").	Addiction is often characterized by cycles of excessive AOD use/problems interspersed with voluntary or coerced periods of abstinence. Recovery is the replacement of these cycles with stable and sustained health. While this process may be marked by diminished frequency and severity of AOD use, depicting such use as a dimension of the recovery experience is a misnomer.

Like other essays on language in this extended series, it is hoped that this latest essay will stir discussion and debate. Challenging prevailing language in the addictions field is not an attempt to forge a politically correct lexicon; it is about forging language that can best incite and sustain long-term addiction recovery and create a community milieu in which such recoveries are welcomed and supported. We don't expect that the *lapse/relapse* language will be shed quickly, but if anti-stigma campaigns achieve increased momentum and effectiveness, we do think the *lapse/relapse* language will be more critically evaluated and eventually abandoned. It is time for this discussion to begin anew.

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Acknowledgement: This topic was addressed at the request of the Philadelphia Department of Behavioral Health and Mental Retardation Services. We would like to thank William Miller for his pioneering essay on the relapse language and John Kelly, Pat Taylor, Tom Hill, Paul Poplawski, and Pat Scoles for their comments and suggestions on early drafts of this paper.

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Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2010), Today we stand. Posted at **www.williamwhitepapers.com**

Today We Stand

PRO-ACT Recovery Walks 2010
National Rally for Recovery Site
September 25, 2010
Philadelphia Pennsylvania

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Introductory Note: Recovery celebration events grew throughout the first decade of the 21st century—from a handful of fledgling recovery marches that drew a few hundred people in 2000 to more than 100,000 recovering people and their families and friends participating in more than 200 recovery month celebration events during September 2010. Faces and Voices of Recovery provided central coordination of these events and designated one event each year in a different city to be the "national hub" event. The 2010 hub event was held in Philadelphia, Pennsylvania. The event drew more than 11,000 people who participated in a public march followed by speakers, entertainment and recovery-focused informational booths at Penn's Landing. Two moments stand out in this event for me. The first was a point in the march on Market Street where the march crested a bridge revealing recovering people as far as the eyes could see before me and behind me. The second was a scene of a woman in her 60s wearing a purple honor guard sash noting her 39 years of recovery sitting on a step beside the march in private counsel with a young woman whose sign at her feet said simply "89 days." The former image was something I never thought I would see in my lifetime; the latter stood as a poignant portrait of the very essence of the recovery advocacy and peer recovery support movement. Below are my brief remarks to the crowd that day.

Today We Stand

I speak to you this morning as a person in long-term addiction recovery and as a recovery historian, and am particularly delighted to do so from the city I think of as the recovery capital of the world. No city has devoted more resources to the promotion and celebration of recovery or done more to mobilize recovering people and their families as a healing force than has the City of

Philadelphia. This would not have been possible without the strong support of Mayor Michael Nutter, the vision of Dr. Arthur Evans, Jr., the tenaciousness of Bev Haberle and other local recovery advocates, and the national leadership of people like Pat Taylor, Carol McDaid, Dr. Tom McLellan, and Dr. Westley Clark.

Although Dr. Benjamin Rush first wrote from this city in 1794 that addiction was a medical rather than moral problem, it wasn't until the National Council on Alcoholism's Operation Understanding in 1976 that 52 prominent Americans publicly declared their long-term recovery from alcoholism. But the faces of First Ladies and other dignitaries in recovery disappeared from television screens and newspaper headlines amidst the restigmatization, demedicalization, and recriminalization of addiction in the 1980s and 1990s.

Ten years ago, I wrote of a new recovery advocacy movement rising in the United States. I described the simple but transformative ideas that were emerging from new and renewed grassroots recovery advocacy organizations. In the earliest days of this movement, we announced that addiction recovery is a reality in the lives of millions of individuals and families, and we offered ourselves as living proof of that proclamation. We noted the many pathways to addiction recovery and declared that all should be cause for celebration. We observed that recovery flourishes in supportive communities, and we affirmed that recovery gives back what addiction has taken from individuals, families, and communities.

In October 2001, recovery advocates from around the United States met in St. Paul, Minnesota, to craft the future of this movement through the leadership of Faces and Voices of Recovery. We spoke of a day when recovering people and their families and friends would mass as far as the eye could see in cities across the country. We spoke of a day when families who had lost a loved one to addiction would march to save others. We spoke of a coming day when people with days of recovery would march beside men and women with decades of recovery. We spoke of a day when those in Twelve Step fellowships would march arm-in-arm with people in secular and religious pathways of recovery. We spoke of a day when people whose recoveries began in therapeutic communities would stand in fraternity with people in methadone-assisted recovery—all of us putting aside our differences and celebrating the growing varieties and styles of recovery experience. We even envisioned a day when people in recovery from countries around the world would stand collectively to carry the advocacy torch.

That day, which we thought would take decades to achieve, has arrived. We stand today as the living fulfillment of that vision. Today, I received an email that 200 recovering people and their families marched the streets of Tokyo this week in Japan's first ever recovery march. Today, we stand, here and abroad, reaching across geographical, political, racial, and cultural barriers, to mobilize our growing numbers and influence. Today, we stand to reach our goal of engaging those who still suffer and creating a world in which recovery is supported and celebrated. Today, we stand to remind ourselves and to send a message to those still wounded: <u>Recovery is contagious</u>. If you want it, you have to get close to it and stay close to it. You have to catch it and keep catching it. And you have to pass it on to others!

For far too long we have knelt with bowed heads, not in humility or prayer, but in shame. Today, we stand as one—in our gratitude for the fruits of recovery and in our commitment to service. Today, we stand to write the future of addiction recovery in America.

Today, we stand.



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Laudet, A. & White, W. (2010). What are your priorities right now? Identifying service needs across recovery stages to inform service development. *Journal of Substance Abuse Treatment*, 38, 51-59. Posted at **www.williamwhitepapers.com**

What are Your Priorities Right Now? Identifying Service Needs across Recovery Stages to Inform Service Development

Abstract

Substance use disorders (SUD) are, for many, chronic conditions that are typically associated with severe impairments in multiple areas of functioning. "Recovery" from SUD is, for most, a lengthy process; improvements in other areas of functioning do not necessarily follow the attainment of abstinence. The current SUD service model providing intense, short-term, symptom-focused services is ill-suited to address these issues. A recovery-oriented model of care is emerging, which provides coordinated recovery-support services using a chronic-care model of sustained recovery management. Information is needed about substance users' priorities, particularly persons in recovery who are not currently enrolled in treatment, to guide the development of recovery-oriented systems. As a first step in filling this gap, we present qualitative data on current life priorities among a sample of individuals that collectively represent successive recovery stages (N = 356). Findings suggest that many areas of functioning remain challenging long after abstinence is attained, most notably employment and education, family/social relations, and housing. Although the ranking of priorities changes somewhat across recovery stages, employment is consistently the second most important priority, behind working on one's recovery. Study limitations are noted, and the implications of findings for the development and evaluation of recovery-oriented services are discussed.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Best, D. Gow, J., Knox, T., Taylor, A. & White, W. (2011) Recovery from heroin or alcohol dependence: A qualitative account of the recovery experience in Glasgow. *Journal of Drug Issues*, 41(3), 359-378. Posted at **www.williamwhitepapers.com**

Recovery from Heroin or Alcohol Dependence: A Qualitative Account of the Recovery Experience in Glasgow

Abstract

While it is increasingly recognized that recovery from dependent use of heroin or alcohol is possible, little is known about the long-term process of recovery. A study in Glasgow, Scotland used interviews and self-completed questionnaires to investigate the recovery journeys of former problematic users of heroin or alcohol. Qualitative data showed that recovery was understood as including but transcending freedom from dependence, and that most participants saw their own recovery as an ongoing process rather than a time-limited milestone. Motivating factors were usually negative personal experiences—with former heroin users more likely to cite "the lifestyle" and former alcohol users their behavior and health problems – and more positively around issues of personal identity. Social factors were often cited as key in sustaining recovery, especially peer support. An understanding of the views and perceptions of those who have experienced recovery from dependent use of alcohol or heroin can help to develop and improve recovery services and support.



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2011) The Philadelphia Clean Machine: A story of basketball and addiction recovery. Posted at **www.williamwhitepapers.com**

The Philadelphia Clean Machine: A Story of Basketball and Addiction Recovery

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"We wanted to stay in shape, and we wanted to stay clean."

At the 2010 National Rally for Recovery, Philadelphia, Pennsylvania was acknowledged as "the recovery capital of the world." That title comes in part from Philadelphia having hosted a stream of national and international visitors seeking to understand and emulate the city's unique addiction recovery support systems. Philadelphia has distinguished itself through its vibrant and diverse communities of recovery; a powerful local recovery advocacy movement; an increasingly recovery-focused treatment system; its growing network of recovery homes, schools, and industries; and its celebration of recovery through the vehicles of art, music, drama, and sport. The purpose of this paper is to describe a small but important story within this larger recovery-oriented systems transformation process that has unfolded in Philadelphia. This is the story of the Philadelphia Clean Machine—a group of recovering addicts who are using basketball as a catalyst for rebuilding their lives.

I

It started in the mid-1980s as a confluence of need and inspiration. The need was experienced by men who once lived on Philadelphia's basketball courts before their addictions took them to the streets. They were men whose addictions cut short dreams of college ball and careers in the NBA, but who are now seeking to recapture and relive part of that dream. Some were ex-stars trying to recapture some of their lost glory. All were men struggling in their early recoveries to fill the void of leaving "the life"—men whose earlier efforts to return to the courts as men in recovery had often brought them into contact with the very negativity they were seeking to escape.

The inspiration came in 1986 when two such men who had started playing basketball after their NA meetings developed the idea of creating a basketball team of recovering addicts. They started playing twice a week at a gym at 22nd and Cecil B. Moore Avenue. At first, some came to play

ball and some came to stay clean, but as their members grew in size and commitment, a more formal team was created with the vision of encouraging the development of other teams of recovering addicts who could compete in regular tournaments. In 1989, the Philadelphia Clean Machine was formally created to pursue this vision. Nearly a quarter of a century later, that vision has grown to something its founders could not have imagined.

Today, the Philadelphia Clean Machine is a blend of recovery culture and basketball culture. Since its inception, it has engaged more than 300 men from Philadelphia in intense athletic competition (regular tryouts, practices, and 6-8 road trips for tournaments per year), and it has sparked the development of teams of recovering addicts in 25-30 other cities, mostly in the Northeastern United States. The Philadelphia Clean Machine has participated in tournaments as far north as Vancouver, Canada, and as far south as Atlanta and Decatur, Georgia. Since its inception, the team has been completely self-sufficient financially, with members paying for their uniforms and all costs of travel. In Philadelphia, there are now three 12-man teams who represent the Clean Machine.

II

There are several distinctive features to the Philadelphia Clean Machine and its tournaments. First, all of the players and coaches of the Clean Machine and the teams they play in tournaments are in recovery. Second, basketball exists as the centerpiece of a larger focus on the physical, mental, and spiritual development of the players (e.g., the team now has its own volunteer therapist and volunteer nutritionist). Third, basketball games are nested in a larger rubric of mutual support among team members, recovery support meetings (speaker jams) held at the tournaments, and fundraisers that support other recovery community activities. Fourth, families and members of the larger recovery community are actively involved in supporting the team.

Although being a member of NA or AA is not a requirement for participation in the Clean Machine, most members are actively involved in one or more recovery fellowships. The requirement for Clean Machine membership is “a willingness to change your life and help the community.” In the early years of the Clean Machine, members had to have 30 days of clean time before they could practice or play in a game, and any member who used could not play until that clean time was re-established. Today, the clean time requirement for playing continues, but a member who has used is more likely to be embraced than abandoned. Such a member is re-engaged by other team members, encouraged to get his recovery re-stabilized, and re-integrated into practices until everyone is comfortable with him returning to active play status.

III

What has the Clean Machine meant to the players? It is about being with kindred spirits who share a commitment to recovery. It is about a second chance and the pure enjoyment of the game. It is about escaping the negativity of one’s environment. It is about being in a safe place where nobody is going to threaten anyone or fight or pull a gun. It is about having a cultural home—a sanctuary that is secure and comfortable. It is about being part of something positive. It is about healing wounded bodies and spirits.

And many of these effects occur off the basketball court. When I asked representatives about the most therapeutic moments within the Clean Machine experience, they did not talk about the basketball games or even the recovery support meetings often held in tandem with the tournaments. They talked about what happens on those long drives to tournaments—the laughing, the crying, the sharing of stories, the sharing of dreams, the unconditional support, and all the things that happened along the way (snow storms, flat tires, police stops, people encounters of all varieties). They talked about what it meant

for their sons to travel with them and to grow up in such a positive recovery environment. Today, there are men involved with the Clean Machine with more than 25 years of continuous recovery and more than two decades of involvement in this unique recovery institution.

IV

Addiction is a transformative, all-consuming experience, and many people with severe alcohol and other drug problems have been deeply enmeshed in a culture of addiction—a street culture—with its own distinct language, values, rules, roles, rituals, and relationships. For some, ending the drug relationship is inseparable from escaping enmeshment in this drug culture. For some, the transition into health requires enmeshment in a culture of recovery that is also transformative and all-consuming. The culture of recovery in the United States is growing beyond encounters of mutual support "in the rooms" to encompass all kinds of recovery support activities. The Philadelphia Clean Machine is an example of such a new recovery support structure organized by and for people in addiction recovery.

A day will soon come when communities across the world will contain vibrant recovery cultures through which the recovery experience will be expressed through the vehicles of mutual support, community service, music, art, theatre, comedy, and sport. The city of Philadelphia and groups like the Philadelphia Clean Machine are revealing the healing power of these cultures of recovery.

Acknowledgement: Thanks to Anthony W. and Milton M. for their willingness to share the history of the Philadelphia Clean Machine. Support for development of this paper was provided by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Deal. D.A., Folks, W.C. & White, W.L. (2011). Methadone Maintenance Patients in a Residential Rehabilitation Program: The Eagleville Experience. Posted at **www.williamwhitepapers.com**

Methadone Maintenance Patients in a Residential Rehabilitation Program: The Eagleville Experience

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Methadone maintenance (MM) (provided through specialized opioid treatment programs, OTPs) and therapeutic community (TC) treatments for addiction have evolved as independent, often competing, addiction treatment modalities with widely varying philosophies and clinical protocol (White, 1998). Although both approaches have been positively evaluated in treatment outcome studies (De Leon, 2000, 2008; Kreek & Vocci, 2002), rarely have they been provided jointly through concurrent, sequential or integrated models of care. For example, a survey of 380 TCs revealed only 5.4% of traditional TCs currently providing MM as part of their service menu (Roman, 2005), and the historical antipathy between MM and TC proponents has limited collaborative ventures and referrals of patients between these modalities (Hettema & Sorensen, 2009; White, 1998).

The potential benefits of such collaboration are suggested by several findings. First, there are high rates of co-occurring dependencies on alcohol, cocaine and benzodiazepines among opioid dependent patients entering OTPs (Dobler-Mikola, Hattenscwiller, Melli, et al, 2005; Hubbard, Marsden, Rachal, et al, 1989; Kreek, 1978; Raffa, Grebely, Tossonian, et al, 2007; Wedekind, Karg, Luedecke, et al, 2010). Co-occurring drug dependencies compromise MM patients' clinical engagement and recovery outcomes and increase risks for drug-related medical problems and mortality (Brands, Blacke, Marsh, et al, 2008; Ryder, Cullen, Barry, et al, 2009; Stenbacka, Beck, Leifman, et al, 2007). Efforts to create interventions to address co-occurring drug dependencies reveal promising pharmacological and psychosocial/behavioral adjuncts that could be integrated into OTPs or provided by traditional residential and outpatients addiction treatment programs in tandem with MM treatment (Bickel, Marion & Lowinson, 1987; Bickel, Ruzzuto, Zielony, et al, 1988-89; Castells. Kosten, Cappella, et al, 2009; Gordis, 1991; Gossop. Stewart & Marsden, 2006; Kletter, 2003; Petry & Martin, 2002; Tzilos, Rhodes, Ledgerwood , et al, 2009; Villano, Rosenblum, Magura & Fong, 2002; Weinstock, Rash & Petry, 2010).

Second, methadone patients are at high risk of relapse following the cessation of MM (Joseph, Stancliff & Langrod, 2000; Magura & Rosenblum, 2001), and could potentially benefit from TC services as a source of support through the tapering and

post-maintenance recovery stabilization period (Kaufman, 1979; Sorensen, Acampora & Deitch, 1984).

Third, the positive effects of TCs are offset by low attraction and retention rates compared to MM within an OTP (Simpson, 1981). Combining these modalities might attract a larger pool of opioid dependent persons in need of treatment and retain patients long enough to achieve the time-dependent benefits of each.

Forth, there are many TC patients with histories of chronically relapsing opioid dependence and multiple past admissions to TCs and other traditionally defined "drug free" programs. Nationally, 78% of persons admitted to addiction treatment with a primary drug choice of heroin have one or more prior episodes of treatment and 24.6% have 5 or more past treatment admissions (SAMHSA, 2004). Opioid dependent persons who are currently being repeatedly recycled through drug free programs could potentially benefit from the use of methadone as a pharmacological adjunct in their efforts to achieve stable, long-term recovery (Greenberg, Hall & Sorensen, 2007).

Early experiments (1970s) in collaboration between MM clinics and TCs included pilots at Tinley Park, Su Casa, Via Avanta, and Samaritan House (Kaufman, 1979). The potential for collaboration between OTPs and TCs has been historically limited by two factors: 1) the less than widespread integration of psychosocial support services within mainstream OTPs, and 2) an anti-medication bias within traditional drug rehabilitation programs that often resulted in the denial of admission of MM patients seeking treatment of non-opiod drug dependencies (Greenberg, Hall & Sorenson, 2007; White & Torres, 2010).

Four studies experimenting with the treatment of co-morbid drug dependencies in OTP patients in non-OTP treatment settings suggest that such bifurcation of treatment philosophies and clinical protocol into OTPO and drug-free treatment silos is based on false assumptions and is clinically counter-productive.

Kipnis and colleagues (2001) studied 220 MM patients treated for alcohol dependence within New York State's publicly funded inpatient Addiction Treatment Centers (ATC) following extensive staff training on the value of methadone maintenance. Within this one-year pilot study, 80% of the MM patients successfully completed ATC treatment. As a result of this successful experience, MM patients are now routinely treated within the ATC network with methadone provided to these patients onsite at the ATC.

De Leon and colleagues (1995) studied whether outcomes in OTPs could be enhanced by involving patients in a therapeutic community (TC) based day treatment regime. They compared the clinical outcomes of 115 MM patients who participated in the TC-based day treatment program (Passages) with 212 matched MM patients who received MM only. The patients in Passages exhibited greater reductions in drug use, needle use, criminal activity and psychopathology.

Sorensen and colleagues (2009) compared 24-month outcomes of 125 methadone patients admitted into a therapeutic community (TC) treatment program with 106 opioid dependent patients who were not on medication admitted to the same program. They concluded that MM patients admitted to the TC had positive outcomes comparable to those patients not on medication as measured by dimensions of illicit opioid use, non-opioid drug use and injection- and sex-risk behaviors.

Chen and colleagues explored the utilization of special adjuncts added to a TC to accommodate the treatment of methadone patients (Chen, Masson, Sorensen & Greenberg, 2009). They found that 97% of MM patients participated in methadone support group and that 52% used acupuncture services, but that utilization of psychiatric services was actually lower for MM patients than other TC residents in spite of high rates of lifetime and current psychiatric illness. This latter finding may be related to evidence that patients with histories of opioid addiction and co-occurring psychiatric illness may receive special

benefits from the stabilizing properties of methadone (Musselman & Kell, 1995).

The inclusion of MM patients in modified TCs is part of a larger process of adapting traditional drug-free treatment to the needs of multiple clinical populations (White, Deitch, & De Leon. 2010). The Kipnis, De Leon, Sorensen and Chen studies and a body of related literature (Cheung & Ch'ien, 1999; Greenberg, Hall & Sorenson, 2007; Kaufman, 1979; Sorenson, Acampora & Deitch, 1984; Sorenson, Deitch & Acampora, 1984; Zweben, Aly, Martin, et al, 1999) all suggest potential benefits of collaboration across the historically dichotomized worlds of OTPs and TCs and the need to transcend polarized debates of harm reduction versus abstinence-based treatment (Kellogg, 2003; Larney, Corcoran, Wodak & Dolan, 2006; Marlatt, Blume & Parks, 2001). These studies also underscore that such collaborations from their beginning have treated a population experiencing great problem severity, complexity and chronicity (Kaufman, 1979).

The present study extends this literature by examining the front line experience of integrating MM patients into the residential rehabilitation units of Eagleville Hospital, a once traditional drug-free TC. This study examines the historical attitudes toward methadone maintenance among Eagleville staff, the sources that prompted a change in MM patient exclusion policies, fears related to the expected negative outcomes of such integration and the actual positive outcomes experienced through the integration process. The paper closes with recommendations on process steps that can be used by traditionally drug-free programs to successfully integrate methadone patients.

Setting: Eagleville Hospital

Eagleville Hospital was first founded in 1909 for patients suffering from the "white plague" (tuberculosis). It functioned in that capacity until it was reconstituted in 1965 as a hospital specializing in the treatment of alcoholism. Three years later, Eagleville expanded its mission to include drug addiction and became one of the first programs in the United States to provide integrated treatment of alcohol and drug addiction. Self-identifying itself as one of the early therapeutic communities, Eagleville Hospital programs grew in size and clinical sophistication over the intervening years to include specialized treatment of women and their children, halfway house and day treatment services, a day school program for adolescents, and treatment services for prisoners at Graterford Prison. Today, Eagleville Hospital's 318 bed campus provides medically supervised detoxification, specialized inpatient programs for men and women, a medical specialty unit, and dual diagnosis programs as well as non-hospital programs. (Eagleville also provides an Acute Gero-psychiatric Service--20 beds). Alcohol and other Drug (AOD) treatment programs are provided in dedicated units within five patient care buildings, which house the following levels of care:

- Level 4A Medical Detoxification (22 beds)
- Level 4B Hospital Rehabilitation (26 beds)
- Level 3A Non-hospital Detoxification (14 beds)
- Level 3B/3C Short and Moderate Stay Rehabilitation (85 beds)
- Level 3B/3C Co-occurring Disorders Rehabilitation (123 beds)

Eagleville Hospital is licensed by the Department of Health, approved by the Division of Drug and Alcohol Licensing for all residential treatment services, licensed by the Department of Public Welfare for as an adult Residential Treatment Facility for co-occurring disorders, approved by regulatory authorities to treat methadone maintenance patients who need detoxification or rehabilitation, and is accredited by the Joint Commission on the Accreditation of Health Care Facilities.

A total complement of 85 beds is utilized for the delivery of "general" short and moderate stay non-hospital rehabilitation services (Level 3B/3C Non-hospital

Medically Monitored Rehabilitation). This program is designed to treat patients with high substance use disorders and low psychiatric needs. Physicians provide care to patients on an as needed basis. Nursing staff are available 24 hours a day, 7 days per week and share responsibility for milieu management with counselors and clinical assistants. All medications prescribed by the physician are administered by a nurse. Group therapists and recovery educators provide group and individual therapy, family sessions, addiction and mental health education, and 12 step recovery experiences. Psychiatric consultation is available. Therapists provide group and individual therapy. One unit has recently been converted for women only, allowing gender specific group therapy and education on topics of trauma and abuse. Included within the rehab complement is a separate, specialized program of 23 beds. The Eagleville Recovery Program is housed in the Gerstley Building and is designed for men referred by, or with current involvement in, the criminal justice system.

Early Attitudes toward Methadone Maintenance

At the time Eagleville Hospital was redefining its mission as that of addiction treatment, considerable hostility existed between newly rising drug-free therapeutic communities and methadone maintenance programs, both of whom were competing for limited resources and struggling to gain professional credibility and cultural legitimacy (White, 1998). Eagleville staff attitudes toward MM were typical of this period and lingered through the era of increased education and professionalization. In those early days we viewed medication, even psychiatric medication, as a “cop-out” and tried to convince people not to use it or to get off it.

Although attitudes toward methadone and other medications softened somewhat over the years, particularly for people who had failed multiple times in drug-free treatment, there was still a deep undercurrent of thought that MM 1) simply substituted one drug addiction for another, 2) failed to address the characterological (cognitive, emotional, relational, spiritual) roots of addiction, 3) generated its own cognitive, emotional and behavioral impairments, and 4) was a form of government social control and not an aid to personal recovery. Based on these beliefs, Eagleville had maintained a policy of refusing to admit MM patients to its residential rehab units unless the patient agreed to be detoxified first. Eagleville Hospital did use methadone within its detox unit when the unit first opened in 1983, then shifted to alternative medications, before returning to the use of methadone as more persons entered with histories of using high-purity heroin. In those early years, we would only take a patient on methadone into detox if they were on 20 milligrams or less and then they would be tapered to 0 milligrams over five days.

The Context and Process of Change

Several influences set the stage for changes in Eagleville’s attitudes and policies toward methadone. The most important of these included the:

- increased number of Eagleville staff with education and training in addictions who had been exposed to studies on the scientific effectiveness of MM
- growing emphasis in the field on integrating evidence-based practices into addiction treatment and the broader field’s recognition of MM as an evidence-based practice
- development of a formal training program on evidence-based treatment initiated at Eagleville in collaboration with Drexel Behavioral Health
- re-examination of traditional philosophies/policies in light of the recovery-focused systems transformation processes of the Philadelphia Department of Behavioral Health
- discovery of potential benefits of medication drawn from Eagleville Hospital units specializing in the treatment of co-

occurring substance use and psychiatric disorders

- lowering of daily census as a result of managed care and the subsequent admission of more clinically complex patients who would have been screened out in earlier years,
- advocacy and threatened law suits by the Pennsylvania Association for the Treatment of Opioid Dependence for denying MM patients full access to care, and
- recognition of a new generation of opioid addicts for whom combined MM and TC treatment might be particularly beneficial.

The first change in methadone policy at Eagleville Hospital began in 2000 with the first admissions of MM patients for detoxification related to benzodiazepine dependence. That initial experience led to considering admitting MM patients to the rehabilitation units in response to isolated referrals from MM programs began in 2002, but there remained considerable fear about the prospects of such inclusion. Serious discussions about admitting MM patients to the rehab units began in the fall of 2005 in response to increased calls from methadone clinics asking if Eagleville would consider treating co-occurring drug dependencies and psychiatric disorders of MM patients. Treating MM patients in a separate unit was considered first, mostly out of fear of the MM patient, but that idea was abandoned when a respected clinician and former Eagleville counselor shared his current positive experiences treating MM patients in a rehab setting. The former staff member challenged the segregation of MM patients as discriminatory and clinically unwise.

By the spring of 2006, discussions among Eagleville's clinical leaders about admitting MM patients had shifted from its potential to increase patient census to a broader evaluation of Eagleville's clinical philosophy and programs. The question of admitting MM patients was integrated into a larger discussion of how Eagleville could more fully integrate principles of recovery management into its treatment approach. Prolonged and sometimes heated discussions ensued on the idea of multiple pathways of long-term recovery, the role of medication within some of these pathways, and how Eagleville could best support the long-term recoveries of an increasingly diverse patient population. A paper disseminated on stigma and medication-assisted recovery distributed by the Philadelphia Department of Behavioral Health was also influential in these discussions (White & Torres, 2010).

A decision was made in May 2006 to admit MM patients to Eagleville and application was made for a license to treat MM patients in the rehab units. The application was approved and the first MM patient was admitted to a rehab unit in 2007. In 2007, the average number of MM patients in rehab at Eagleville on any day increased from three in May and July and by December had risen to 10. That number has progressively risen from an average of 13 through 2008, 17 in 2009 and 24 between January and June of 2010. Referral of MM patients for treatment of non-opioid drug dependencies come primarily from opioid treatment programs (OTPs, 78%), the criminal justice system (10%) and general or psychiatric hospitals (10%). Methadone patients are now fully integrated into the rehab units, with methadone being dispensed onsite at Eagleville to these patients each morning and in again in the afternoon for those on split dosing, and patients referred back to their OTP of origin upon discharge. Other than medication dispensing, treatment of MM patients at Eagleville is indistinguishable from the treatment received by other Eagleville patients.

Early Fears versus Actual Experience

Five fears dominated early discussions regarding the potential inclusion of MM patients within the rehab units at Eagleville Hospital. While it is somewhat embarrassing to acknowledge these fears in light of subsequent experience, they reveal many of the stereotyped attitudes MM patients confront on a daily basis. The first staff fear was that other Eagleville patients would want to seek methadone treatment if

they were exposed to MM patients. This simply did not happen, not because such exposure created antipathy toward methadone as a medication but because patients were repelled by the rigorous demands of MM, the disruption of daily lifestyle imposed by involvement in MM and their perception that MM programs lacked a recovery oriented milieu. Other patients were particularly discouraged from considering methadone when they heard MM patients speak of the demands of clinic visits, the travel limitations posed by MM and the negative attitudes toward methadone encountered in 12-Step groups, e.g., not being allowed to speak.

The second staff fear was that MM patients would destroy the therapeutic milieu by "being high" ("nodding out") on the units and in groups. This occurred rarely as patients stabilized on personally optimal doses of methadone were indistinguishable in appearance and functioning from patients on no medication. Even staff with the long pre-recovery addiction histories and the longest professional experience could not identify which patients were being maintained on methadone. In the rare cases where a MM patient self-reported sedating effects of methadone or where such effects were observed, these were able to be resolved either through an adjustment of methadone dose or by split dosing.

The third staff fear was that MM patients would not be fully accepted by other patients and by staff on the units. This fear contributed to the earlier noted consideration of a special unit for MM patients. A minimum level of staff and patient education prevented such rejection of MM patients from happening. The number of young (under 30), professionally-trained staff at Eagleville made this transition far easier than it might have been in earlier years with a mostly older, ex-addict counseling staff. Once integrated into the units, MM patients wrestled with the same kinds of recovery issues as those patients not on medication, making their methadone use less and less of an issue as treatment proceeded.

The fourth major staff fear, a corollary of the third, was that other patients and staff would try to convince MM patients to stop their methadone use. Again, staff/patient education on multiple pathways of long-term recovery and the legitimacy of medication-assisted recovery as one recovery pathway checked any such persuasion efforts. Only three patients have requested to taper from MM since MM patients began being admitted to the rehab units in 2007, and these were personal rather than staff-influenced decisions.

The fifth fear was that there would be problems integrating MM patients into local recovery mutual aid societies, given the emphasis of such linkage at Eagleville. This actually proved to be true and has required both preparing MM patients on how to handle the anti-methadone bias they encounter in local 12-Step meetings (e.g., suggesting that he/she address issues related to medication disclosure with his or her sponsor) as well as assertive attempts by staff to locate medication-friendly meetings.

In retrospect, the adjustments of MM patients to the TC environment had as more to do with issues other than medication. These issues included the greater problem severity and complexity (more medical/psychiatric problems; less recovery supports in their natural environment) of a population not successful within mainstream MM treatment and the transition from an outpatient treatment setting to a more structured and demanding residential treatment setting.

Clinical Outcomes

To look at the profile and clinical outcomes of MM patients admitted to the rehab units at Eagleville Hospital, admissions between January 1, 2010 and June 30, 2010 were analyzed. A total of 88 MM patients were admitted during this time period. The MM patient cohort was gender balanced (52% male; 48% female); ranged in age from 19 to 58 with an average age of 33; and were predominately White (White, 91%; Black, 7% and Hispanic, 2%). Ten percent were admitted for detox only; 35% for rehab only; and 55% for both detox and

rehab (detox here referring to detoxification from drugs such as alcohol, cocaine, benzodiazepines and not from methadone). A particularly striking figure is that 55 (69.6%) of the MM patients were admitted or subsequently transferred to a unit specializing in the treatment of co-occurring psychiatric disorders. It is unclear whether MM patients with co-occurring opioid and other substance use disorders have a higher rate of psychiatric illness or whether these patients are being referred to Eagleville Hospital because of its reputation for treatment such complex clinical profiles.

Key initial questions examined were whether MM patients could be attracted, engaged and integrated into the rehab units at Eagleville Hospital. Three key indicators are number of admissions, length of stay and discharge status. The Eagleville program has attracted MM patients, with such patients now constituting 10% of the total treatment population. There were no significant differences between retention rates and length of stays for MM patients and patients not on medications. In comparing discharge status, the MM patients had a slightly higher discharge rate for breaking rules (7% compared to 2% for total hospital population) and leaving with consent (7% compared to 2% for total hospital population in both categories); comparable discharge rates for non-compliance (1% compared to .63%) and medical transfer (1% compared with 1.86%); a lower AMA/AWOL rate (7% compared to 12.6%); and a better positive completion rate (77% compared to 64%). Future efforts will focus on comparing the post-treatment recovery outcomes of patients who use methadone to support their continued recovery and patients supporting their recoveries without methadone.

Summary and Lessons Learned

Based on the Eagleville experience and the other published efforts we have described to integrate MM patients within traditional residential and outpatient addiction treatment programs, there are a number of recommendations we would proffer regarding such integration.

1. Educate top organizational leadership on advantages and obstacles to integrated MM and psychosocial treatment and negotiate "buy-in" for sustained problem solving through the implementation process (Zweben, Aly, Martin, et al, 1999).

2. Provide methadone dispensing on site, where possible, to avoid the expense and disruption of regular travel to the OTP.

3. Address administrative issues and operational concerns related to licensing, methadone storage and security, dispensing procedures, billing procedures related to medication and communication protocol with physicians and OTPs.

4. Avoid mandating inclusion of MM patients unless a process is developed to assure that this experience is a positive one for the MM patients/families, other patients/families, and the clinical staff.

5. Address long-held biases against MM through a process of continued professional education about the proven scientific efficacy of MM as a medical treatment for opioid dependence (See Greenberg, Hall & Sorensen, 2007, for training formats, topics and tips). Such education/training should be infused with the following propositions:

- There are multiple pathways to long-term addiction recovery, and all are cause for celebration.
- Medication-assisted recovery is a legitimate pathway of recovery and is being increasingly recognized as such.
- Persons using medication to support their recoveries can benefit from the same psychosocial/behavioral treatment and peer-based recovery support available to those supporting their recoveries without benefit of medication.
- Persons using medication to support their recoveries may be of even greater need of professional and peer-based recovery support due to the ambivalence to outright hostility toward the use of medication to support addiction recovery they often

encounter from family, friends, co-workers, service professionals, peers in the recovery community and the public/media.

- Successful treatment outcome—recovery—is about functionality—clinical remission, global (physical, emotional, cognitive, relational, spiritual) health and citizenship; whether this is achieved with or without discontinuance of methadone or other medication is a matter of recovery style, not the line demarcating addiction and recovery initiation (White & Torres, 2010).

6. Establish formal collaborative agreements with referring MM programs to assure coordination of respective treatment plans and best stewardship of joint organizational resources, e.g., avoiding scheduling conflicts, duplicative services, contradictory messages, breaches of confidentiality in inter-organizational communications, etc. (Kipnis, et al, 2001); reciprocal staff visits, joint clinical staffing/supervision and joint planning of post-treatment continuing care are also potential strategies for enhanced service integration (Zweben, et al, 1999).

7. Where possible, provide methadone onsite during inpatient or residential treatment and re-evaluate optimal methadone dose as other drug use reduces and ceases; polydrug using MM patients are often undermedicated due to physician fears of untoward drug interactions (Kipnis, et al, 2001).

8. Assure that MM patients are adequately dose stabilized before they enter treatment in rehab units to avoid the clinically unproductive time a client is continuing to experience some withdrawal distress (under-medication) or signs of sedation/intoxication (over-medication).

9. Avoid creating a “class system within the patient population” via specialized tracks through which MM patients are marginalized and stigmatized within the treatment milieu; fully integrating MM patients into all treatment activities (Greenberg, et al, 2007; Kipnis, et al, 2001).

10. Designate a lead person to serve as patient educator, staff trainer, advocate, and liaison on methadone-related issues (Greenberg, et al, 2007).

11. Evaluate the risk/benefit of creating a special support track (e.g., weekly support group) for MM patients; this was not done at Eagleville out of fear of isolating and labeling MM patients, but others have described the value of such a group (Zweben, et al, 1999).

12. Maintain liaison with local recovery mutual aid societies to enhance inclusion of MM patients and to link MM patients to medication-assisted recovery support groups, e.g., Methadone Anonymous (Gilman, Galanter & Dermatis, 2001; McGonagle, 1994; See White, 2011 for working with NA).

Most of the literature on MM patients in TCs has focused on the referral of MM patients to TCs. Far less is known about the referral of TC patients to MM. Models of joint collaboration are needed through which patients may move easily across these systems of care over time as well as participate in them concurrently.

There is a growing body of scientific studies and clinical experience confirming the successful integration of MM patients into inpatient and residential addiction treatment programs for treatment of co-occurring, non-opioid substance dependencies and/or treatment of co-occurring psychiatric illness. The experience of Eagleville hospital with such an integration process turned out to be an unexpectedly positive one.

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Acknowledgement: Support for the development of this paper was provided by

the Philadelphia Department of Behavioral Health and Mental Retardation Services.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Best, D., Gow, J. Knox, T., Groshkova, T. & White, W. (2011). Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its predictors. *Drug and Alcohol Review*, 31(3) pp. 334-41. Posted at **www.williamwhitepapers.com**

Mapping the Recovery Stories of Drinkers and Drug Users in Glasgow: Quality of Life and Its Predictors

Abstract

Introduction and aims: The study investigates what 'recovery' means for those who describe themselves as in alcohol or drug recovery.

Design and methods: The project used multiple methods – snowballing, recruitment through recovery groups and adverts in local press – to recruit 205 people (107 in alcohol and 98 in heroin recovery) who reported a lifetime dependence on alcohol and/or heroin; had not used their primary substance in the last year, and perceived themselves to be either recovered or in recovery. They were interviewed by researchers using a structured questionnaire and then a tape-recorded semi-structured interview.

Results: The average total time dependent for heroin users was 10.8 years and for drinkers 15.7 years, but onset and desistance were typically earlier for heroin. Longer time since last use of alcohol or heroin was associated with significantly better quality of life at the time of interview. Greater engagement in meaningful activities was associated with better functioning, and was the strongest predictor of quality of life. The next strongest predictor was number of peers in recovery in the social network. Heroin users in abstinent recovery generally reported better functioning than those in maintained recovery.

Discussion and conclusions: Recovery experiences vary widely, but better functioning is typically reported after longer periods and is associated with supportive peer groups and more engagement in meaningful activities, and supports models promoting the development of peer networks immersed in local communities.



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Citation: White, W., Arria, A. & Moe, J. (2011). Parenting in the context of addiction recovery: Critical research questions. Posted at **www.williamwhitepapers.com**

COMMENTARY

Parenting in the Context of Addiction Recovery: Critical Research Questions

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Abstract

The emergence of recovery as an organizing paradigm in the addictions field is spurring calls for the development of a national recovery research agenda. This article identifies research questions of great concern to parents in recovery, parents of recovering adolescents, addiction professionals, and recovery support specialists seeking to include parent-focused interventions within the treatment and post-treatment recovery support process. Effectively addressing parenting as a treatment and recovery support issue will require mobilizing people in recovery to help shape a recovery research agenda that includes parenting as a prominent focus of research activity.

Research related to alcohol and other drug (AOD) problems has evolved topically through three organizing paradigms: 1) a pathology paradigm (studies of the etiology, epidemiology, personal course, and social costs of AOD problems), 2) an intervention paradigm (studies to evaluate the effectiveness of prevention, early intervention, and treatment approaches), and 3) an emerging resilience and recovery paradigm (studies to elucidate resistance to and resolution of AOD problems; White, 2005, 2008). Research studies flowing from the first two of these governing paradigms have produced an impressive body of knowledge about the causes and consequences of AOD problems and the relative effectiveness of various professional interventions to address these problems.

In spite of such advances, we as a professional field and a country know surprisingly little about people with substantial personal and environmental risk factors for developing severe AOD problems but who do not develop such problems. Moreover, we know very little about the prevalence and natural history of recovery in

the general population. Finally, there is a scarcity of data regarding the frameworks used to describe recovery (e.g., secular, spiritual, religious; natural, professionally-assisted, peer-assisted) and the patterns and processes of long-term personal and family recovery from severe AOD problems (Laudet, 2008).

The purpose of this article, the fifth in a series of papers advocating the development of a national recovery research agenda (Erickson & White, 2009; White & Chaney, 2008; White & Godley, 2007; White & Schulstad, 2009), is to identify research questions of great concern to parents in recovery, parents of recovering adolescents, and addiction professionals and recovery support specialists interested in parent-focused interventions within the treatment and post-treatment recovery support process.

Parents in Recovery

Parental AOD problems can exert a potentially profound influence on family health and the developmental trajectory of children (Brook et al., 2010; Brown & Lewis, 1999; Chassin, Flora, & King, 2004; Eiden, Colder, Edwards, & Leonard, 2009; Hussong, Flora, Curran, Chassin, & Zucker, 2008; Keller, Cummings, Davies, & Mitchell, 2008; King et al., 2009; Marmorstein, Iacono, & McGue, 2009; White & Savage, 2005). Children raised by parents with such problems manifest widely diverse responses, with some revealing remarkable resilience under the worst circumstances while others exhibit significant problems in their development. The harmful influence of parental AOD problems is thought to be exerted through such mechanisms as pre- and post-natal AOD exposure, inadequate bonding and nurturing, disruption of family rituals, family conflict, inadequate monitoring and supervision, and physical and emotional neglect/abandonment (Arria, Moe, & Winters, 2010a).

While the pathology literature (studies of the effects of parental addiction on child development) is voluminous (for recent representative literature, see Bijttebier, Goethals, & Ansoms, 2006; Coyer, 2003; El-Sheikh & Flanagan, 2001; Johnson & Leff, 1999; McLaughlin et al., 2010), few studies have been conducted to explore the effects of parental recovery on child development and more specifically, the effects of parenting style on the prevalence and severity of AOD problems in children of recovering parents (Smith & Hall, 2008). While there are studies that are cause for optimism on these and related issues (Andreas & O'Farrell, 2007; Andreas, O'Farrell, & Fals-Stewart, 2006; Koning, van den Eijnden, Engels, Verdurmen, & Vollebergh, 2011; Mares, van der Vorst, Engels, & Lichtwarck-Aschoff, 2011; Moos & Billings, 1982; Reimuller, Shadur, & Hussong, 2011), definitive answers have yet to be formulated for numerous questions raised by parents in recovery. Because of the authors' tenure in the addictions field and our known interest in parenting and children's issues, we are frequently presented with questions like the following.

Assessing Vulnerability

- Are my children at increased vulnerability for the development of AOD problems because of my addiction?
- Does the vulnerability of children vary by the type of parental addiction (e.g., alcoholism versus heroin addiction)?
- Is the source of this vulnerability fixed (beyond parental, peer, or professional influence) or fluid (amenable to parental, peer, or professional influence over time)?
- Are there indicators that would tell me which of my children might be at greatest vulnerability and in need of special support? Should I be more vigilant during particular periods of development, such as during adolescence?
- Does my recovery status or my spouse/partner's recovery status influence my child's vulnerability or potential prognosis for recovery?

Understanding Parenting in Context of Recovery

- What changes in my family and my children should I anticipate following initiation of my recovery?
- At what stage of recovery are the problems that developed in my relationships with my children during my addiction likely to dissipate? When will things get better?
- How do parenting concerns differ across the stages of recovery and across the developmental ages of children?
- What are the most common parenting mistakes made by parents in recovery?
- Are there special parenting issues for fathers in recovery?
- Should parents who abandoned their children during their active addiction seek to re-establish contact with their children? (Will this harm or benefit the child?) If so, when and how?

Communicating with Children about a Parent's Recovery

- Should I talk about my recovery to my children? If so, when and how?
- When my children hear that addiction is a "chronically relapsing disease," they fear I will return to using. What should I tell them?
- I was in recovery before any of my children were born. Do I need to tell them about my addiction/recovery history?
- How can I best prevent embarrassment of my children potentially resulting from my addiction/recovery history?
- My children sometimes resent the amount of time I am not available to them due to my recovery support meetings and recovery service work. How is such resentment best avoided or managed?
- My children did not live with me during the later stages of my addiction, and I am now trying to rebuild these relationships. What actions on my part will be most effective in this process?

Reducing Vulnerability and Enhancing Resiliency

- Are there any parenting interventions that can lower this vulnerability or that could enhance prognosis for early and full recovery if my child would develop an AOD problem?
- How should I respond to early alcohol or drug use by my children?
- There is a history of severe AOD problems in my family going back at least four generations. What can I do as a parent to help break this intergenerational cycle?
- My child has been diagnosed with ADHD and prescribed stimulants. Given the family history of addiction, will this increase his/her risk of developing a drug problem?
- Should I let my children's physician know that I am concerned about their heightened risk for addiction?

Scientific studies exist that shed light on some of these questions, yet for others, the research is sparse or non-existent. Even in the former case, existing studies have not been synthesized and communicated in venues that are accessible and conveyed in a language understandable to parents in recovery.

Parents with a Child in Recovery

Parenting concerns also extend to parents who are themselves not in recovery but who have a child in recovery. Some of the more common questions we are presented with in this situation include the following.

Understanding Adolescent Recovery and Related Risks

- Are there predictable stages of recovery for adolescents and young adults?
- I have four children, the oldest of whom is now in recovery. Are my

younger children at risk for similar problems because of their older sibling's addiction/recovery status?
- My child just completed adolescent addiction treatment. What is her risk of relapse?
- When, if ever, will the risk of relapse for my child end or at least subside?
- Will my son have to go to AA/NA or other recovery support meetings for the rest of his life?
- I worry that my child's addiction/recovery history could be a cause for discrimination and limit her potential in later life due to the stigma and misconceptions attached to addiction. Is this a legitimate concern?
- Will the legal problems my child has experienced hurt his/her chances for later success? Employment?

Parenting a Recovering Child

- What are the common experiences (problems, pitfalls, and opportunities) of parenting a child entering and progressing through these stages of recovery?
- What actions can I take as a parent to lower this risk? Should alcohol now be removed from our home?
- I live in a community with few recovery support meetings and no young people's meetings. Are there other recovery supports that can help my child?
- It has been suggested that my 16-year-old son might need a recovery coach or live for a while in a recovery home after he completes treatment. Is there research proving that these will enhance my son's recovery chances? How do I as a parent know what kinds of support will be best for my son?
- Is there a danger that the amount of attention required by my recovering daughter could negatively affect my other children? If so, how can I avoid such dangers?
- My child has been in recovery less than a year, is doing very well, and is now planning to go to college. How can I as a parent best support my son's recovery as he enters what is clearly an abstinence-hostile environment? I have heard that some colleges and universities have campus-based recovery programs. Do students in these programs have better recovery rates and better academic achievement than students in recovery entering an educational setting without such special support?

Professional Concerns about Parenting

Addiction professionals, child welfare professionals, and a broad spectrum of other helping professionals (psychologists, social workers, mental health counselors, pastoral counselors) have also asked us how they can best address parenting issues within their helping role. Their questions include the following:

Models for Parenting Support

- Are there models for integrating parent-focused interventions that have been proven to improve recovery outcomes, family health, parent-child relationships, or child health?
- Which strategies are more effective in achieving the above outcomes: parenting skills trainings or programs focusing on parent-child relationship development? Individual versus group formats? Professional versus peer delivery formats?
- What is the ideal time duration of parental support interventions? Weeks? Months? Years? How long is parent-focused program support needed?
- Will clients in treatment voluntarily participate in parenting-focused treatment and recovery support activities?

- To what extent should parent-focused programs differ across cultural contexts?
- What is the most effective setting in which to deliver parent-focused recovery support: treatment setting, recovery community organization, school, etc.?
- What evidence-based models are available for peer-based support for parents in recovery, e.g., parenting guides/sponsors?

Financing Models

- What financing models are available for parent-focused interventions as part of addiction treatment or recovery support services?

Effects of Parenting Supports

- Does engagement of key community institutions in support of parents in recovery enhance recovery, parent-child relationship, and child health outcomes?
- Does engagement of extended family and kinship networks, including key elders, in support of recovering parents enhance these outcomes?

What has struck us in our attempts to respond to these questions is how few scientific studies exist that can inform our efforts to answer these questions.

Toward a Parenting-Focused Research Agenda

The Betty Ford Institute hosted a two-day Critical Issues Conference September 29-October 1, 2010 in Washington, DC on *Breaking Intergenerational Cycles of Addiction: Parent-Focused Strategies*. The Conference brought together more than 50 policy specialists, federal officials, addiction researchers, addiction treatment professionals, parents in recovery, recovery advocates, and child advocates to discuss what we know, need to know, and need to do as a field to address the kinds of concerns we have raised in this paper.

Many recommendations were formulated at this meeting, but one of the most pervasive themes of the discussions was the desperate need for scientifically grounded answers to parenting-related questions as well as scientifically grounded strategies to address parenting as a treatment and recovery support issue. Children affected by parental addiction and recovery and young people in recovery and their parents could be mobilized to help set this research agenda and to help forge a body of experiential knowledge that would collectively help answer some of the critical questions posed in this paper. Fulfilling that agenda once it is created will take sustained consciousness of its importance and a period of dedicated private and public funding. The stakes involved in these questions warrant such a commitment.

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Acknowledgment: Work on this paper was supported in part by SAMHSA contract HHSS28320070006I, Westat Subcontract s8440, Recovery Supports for Adolescents and Families, the National Institute on Drug Abuse (P50-DA02784 and R01-DA14845), and the Betty Ford Institute. The views expressed in this paper are those of the authors and do not necessarily reflect the views or policies of the Department of Health and Human Services.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Groshkova, T., Best, D. & White, W. (2011). Recovery Group Participation Scale (RGPS): Factor structure in alcohol and heroin recovery populations. *Journal of Groups in Addiction and Recovery*, 6(1-2), 76-92. Posted at **www.williamwhitepapers.com**

Recovery Group Participation Scale (RGPS): Factor Structure in Alcohol and Heroin Recovery Populations

Abstract

Recovery group participation is relevant to both clinical and research activity. Its measurement with the Recovery Group Participation Scale (RGPS) is an attempt to have a measurement of participation across a range of recovery groups. The factor structure, among other psychometric properties of the scale, is however, undefined. The present study examined the factor structure and the internal consistency of the RGPS in alcohol and drug recovery populations in Birmingham and Glasgow, United Kingdom. Participants from the Birmingham (n=219) and Glasgow (n=205) recovery studies who had a completed form of the RGPS formed the basis for the factor structure examination. Principal component analysis (PCA) extracted one factor, which accounted for 39.3% and 67.4% in the Birmingham and the Glasgow samples respectively. Overall score on the RGPS were associated with higher quality-of-life scores and with greater self-esteem and social networks of nonusers in recovery. The key question that remains to be addressed is the evolving role of recovery group participation in prospective studies of growth of recovery capital and sustained recovery.

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Citation: White, W. & Sanders, M. (2011). Recovery Journalism: An interview with William White. Posted at **www.williamwhitepapers.com**

Recovery Journalism: An interview with William White

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Mark Sanders: Bill, thank you for agreeing to this interview. Some of the students I teach in the Addiction Studies Program at Governor's State University are quite interested in writing as a professional development activity and have found the papers on your web site quite interesting. I have shared with them some of my own writing experiences but I thought interviewing you might provide additional guidance for them and for others interested in writing within the addictions field.

Bill White: I'm delighted to do it.

Mark Sanders: You have been extremely prolific over the past 25 years having authored more than a dozen books and hundreds of articles. What secrets could you offer aspiring writers in the field?

Bill White: Perhaps the first secret is simply giving free reign to your curiosity. The best writing is as much about answering questions for ourselves as it is conveying information to others. The demands for daily action are so great in our field that few of us have the luxury to regularly reflect on the big and little questions that surround this work. The writer seeks answers to these questions and probes emerging issues. I have always had an insatiable curiosity about addiction and addiction recovery. What I don't know continues to be the source of most of my writing pursuits. Writing is a way to synthesize answers for myself and to offer potential answers for others to consider.

Mark Sanders: What kind of discipline is required to generate the level of writing productivity you have achieved?

Bill White: I write almost every day and recommend that to others, but let me broaden the definition of writing. Aspiring writers can get frozen as they stare at a blank computer screen. That moment is not when writing begins. We are writing when we observe and listen to the field. We are writing when we listen to our own hearts to identify those subjects that seem to be personally calling us. We are writing when we are conducting literature searches on a topic and when we are reading. We are writing when we are posing questions to ourselves and others? We are writing when we are sketching out random thoughts and ideas, outlining and envisioning central themes we

want to convey in a piece of writing. By the time we get to the computer screen to compose, a great deal of writing has already occurred. These earlier steps are an essential incubation or gestation period. Only when such steps are completed will the words flow with any depth to them.

The other key for me is simultaneously sustaining multiple writing projects at all stages of development. It is not unusual for me to have 15-20 projects going at one time, some in the stages of final editing and others nothing but a title on a file folder. I keep a chart of all these projects and "work the chart" be deciding each day which can capture my enthusiasm or which must be taken on now because of this or that submission deadline. Others looking at this chart might well think this is ADHD gone wild and recommend medication, but that system has worked very well for me over several decades of writing.

Another discipline required is the ability to break large projects into their component parts. Organizing and outlining are so critical to good writing and efficient writing. Without them, I would get overwhelmed and paralyzed by the sheer enormity of what I am attempting to do. I focus on the whole when I am conceptualizing and outlining a piece of writing and then I try to not think about the whole again until I have completed all the parts, each of which I think of as a piece unto itself with its own beginning, middle and end.

Finally, good writers build a body of completed work that creates its own momentum for further writing. The first ones are always the hardest—perhaps because we are so self-conscious about the process of writing. You have to write your way through that stage and leave it behind you.

Mark Sanders: I have many students who feel that they have something that they can convey in writing that can impact the addictions field but lack confidence in their ability to write and lack an awareness of how to improve as writers. What recommendations do you have for them?

Bill White: I think the first task of the writer is to live—to build a foundation of experience that can be drawn on to create writing of depth. While that body of experience is building, we can work on the craft of writing. I would recommend that your students seek as broad an experience base as possible and that they develop two simple writing habits—jotting random notes on ideas and experiences that can be filed for future use and regular journaling. I recently incorporated some observations in a paper from a journal I kept while working at a psychiatric facility in 1967. There is a freshness and clarity to such immediate observations that is hard to recapture through the vehicle of memory.

Mark Sanders: The founder of Facebook was only in his early twenties when he founded the company. Do you think the tech savvy of the young generation will be an asset in increasing readership of addictions and recovery writings?

Bill White: I do. I often reflect on how the quality and volume of my work would have both been enhanced if I had the mastery of technology that many twenty-somethings take for granted. Technology is going to transform the process of writing, the forms of such writing and broaden the range of dissemination channels that will be available in the future. I envy your students those possibilities. My understanding of it all is pretty primitive and I often feel I need to hire a 12 year old to help me navigate my way through what your students do so fluidly.

Mark Sanders: In your work as a trainer, you have spoken a great deal about the importance of mentorship. Do you believe that mentorship is also important in recovery journalism, and if so, what advice do you have for students who would like to pursue writing as a career path?

Bill White: I do think mentoring is important to good writing, and I think there are three different aspects to it. First, you must develop content expertise (you have to have something of importance to say). Second, you have to master the writing craft (you have to know how to communicate). And third, you have to learn the dissemination

process (you have to know how to get your writing to the world). I would recommend that your students find people and resources that can enhance their skills in these three areas.

To achieve the first of these goals requires extensive reading, listening, observing and reflecting. All are precursors to writing of great depth and importance. It's important to find people who have such depth of knowledge and learn from them without losing yourself—without becoming an uncritical disciple.

I think the most important aspect of learning to write is reading—finding, collecting and studying the best writers. There are also books on writing and writing workshops that can help with this, but in the end nothing takes the place of writing itself. If you want to be a writer, you must write and write and write—and edit and edit and edit. The latter is what improves the quality of writing over time. The book *The Call to Write*, which is available for free download on my website, offers additional suggestions.

There are also aids to getting published that will be of help to some of your students. For those interested in scholarly writing, the book *Publishing Addiction Science* is in invaluable resource. It is also available free online.

Mark Sanders: Much has been written about the ink of the scholar. Did you believe that you would have an impact on the nature of addictions treatment and recovery when you first started writing on this subject? What, if anything, has surprised you about this?

Bill White: It's very hard to tell whether your writing is really making a difference or not. Even when it is having such an influence, it is often a long time before you will know it. Few of us have the experience of a piece of writing that quickly changes the world. I'll give you an example. Mike Boyle and I began writing about recovery management in the late 1990s—advocating a fundamental redesign of addiction treatment that would move beyond brief, self-contained episodes of care toward a framework of long-term recovery support comparable to the best approaches to the management of chronic disease. We wrote and wrote, and it felt for the longest time that we were writing for only our own benefit. It was like yelling in an empty room and hearing nothing but our own echoes. But in a few years, everyone seemed to be talking about recovery management and recovery-oriented systems of care. It was then that we encountered people who told us how they completely changed their treatment programs after reading our early papers. We had no idea that was going on until much later.

So the question for your students is, "How do you sustain the research and writing when it appears that no one is noticing your work?" Writing is such a solitary activity that sustaining it requires sources of energy that come from inside and that also come from having a small network of support. We need people in our lives who regularly ask us the question, "How's the writing coming?" And we need reviewers who affirm the importance of what we are writing. Most writers need a writing circle of support to keep them going. I have an inner circle of such support to whom I owe more gratitude than I can express.

Mark Sanders: What writers have influenced you the most in your writing?

Bill White: For the type of translational writing I do—exploring implications of science to clinical practice—people like Bill Miller and Keith Humphreys have been quite influential. They are among the smartest people I know and yet their writing is striking for its lack of pretentiousness or self-consciousness. They both write very clearly and as a reader you feel that they really wanted to connect and communicate with you and not just impress you with how smart they are. Keith's book, *Circles of Recovery*, and the book Bill did with Janet C'deBaca on *Quantum Change*, are examples of such connection and clarity of communication.

I also admire writers whose ideas are so fresh and crisp that they remain with you forever. Dr. Thomasina Borkman's article on experiential knowledge and Aurora Levins Morales article on the historian as curandero (healer), both of which are posted on my web

site, are pieces of writing that exerted a profound influence on my work.

I also admire and emulate writers who exert influence by the tenacity of their writing. People like Jay Lewis, Michael Q. Ford, and David Powell each found ways to use regular columns to create a body of influential writing. That inspired much of my recovery advocacy writing. I have learned through this work that influence can come from a body of cumulative work as well as from a single well-timed piece of writing.

Dr. Ernie Kurtz, one of the most important professional mentors in my life, has also influenced me through his own writing and by coaching me on the art of storytelling and by teaching me how to write good history.

Mark Sanders: How important is diversity in writing as it pertains to addictions treatment and recovery?

Bill White: It is important to me to remain very cognizant of the diversity of my readers. I've designed my writing desk to remind me of these diverse audiences. I'm surrounded with artifacts from diverse cultures and countries and objects that remind me I have readers who will filter my words through the lens of gender, age, sexual orientation, and numerous other defining characteristics. After I create a first draft, I try to read it through the experience of each of my constituents, who I personify, e.g., "What would Mark Sanders think of this piece?" and, "How would Mark Sanders have written this piece differently?" My answers to those kinds of questions let me look at every piece of writing from multiple perspectives and add nuances and layers that would not otherwise be there.

Mark Sanders: Many students say to me that they would like to be speakers. Others say they would like to be writers. What is the relationship between these two career paths? Which do you think reaches the most people?

Bill White: They are often interconnected. There are writers who become trainers—I'm thinking of our mutual friend Pam Woll as such an example. Such persons often choose training as a way to market the ideas in their writing. I'm probably the opposite—a speaker who morphed into a writer. The culture of the addictions field is a distinctly oral culture. Our history, traditions, etiquette, core ideas and practices were, until quite recently, conveyed by oral tradition through a master-apprentice system of preparation. The problem with relying solely on this oral tradition is the instability of the field. If I could speak directly to every organization and every person working in the field today, within a few short years any potential influence would have dissipated due to the high turnover of organizations and of the addiction treatment workforce. It was when I kept seeing new faces every time I returned to speak in a state that I sought a form of more lasting influence. That was when I seriously committed myself to writing. My goal was to create written works and a platform for achieving them that would extend my reach geographically and temporally--beyond the United States and beyond my own lifetime. Historically, the written word always outlasts the spoken word, but who knows, with all of our new technologies even that is changing.

Mark Sanders: Your writing over the past decade has increasingly focused on recovery and the audiences have broadened. How would you characterize this stage of your writing career?

Bill White: I spent much of the early stages of my writing career producing books, research reports and article published in the field's scientific journals, but I began a series of articles for *Counselor* in the 1990s that changed that focus. That regular column, which has continued through all of these years, gave me the opportunity to translate scientific and historical research for frontline addiction professionals. The appreciative response to that series also inspired me to branch out and begin writing for various recovery advocacy newsletters and web sites. Over the past decade, my writing has evolved toward an almost exclusive focus on recovery. In fact, I have come to think of this

focus and style of writing as recovery journalism.

Mark Sanders: Could you define what you mean by recovery journalism?

Bill White: Recovery journalism is using writing as a tool to reach our most important constituents: people seeking or in recovery, their family members and allies, and the people on the frontlines of helping them. It is a way of conveying experience, strength and hope to all of these constituents. It is also a way to carry a message of hope and the reality of long-term addiction recovery to the larger culture. The focus of this writing is not on the problem or methods of personal or cultural intervention but on the solutions that recovery offers individuals, families and communities.

It is natural in one's early career in the addiction field to get captivated by the diverse menu of psychoactive drugs and their psychopharmacology and to get enamored with learning about all manner of clinical pathologies. But the ultimate question in terms of our contribution lies in what we know about the solutions to the problem of addiction. I hope your students will get solution-focused far earlier in their careers than I did. That is all I am interested in at this stage of my life, and it is reflected in this style of recovery journalism I am pursuing.

This style of this writing also emphasizes conveying the best experiential, scientific and clinical knowledge in clear, jargon-free language. I think of the whole process as a way of liberating useable knowledge about addiction and recovery.

Mark Sanders: Liberating knowledge?

Bill White: As the addictions field became professionalized, our core knowledge became wrapped in language that became less and less accessible to the public and, more specifically, less accessible to people in need of recovery. The best addiction and recovery science is locked up in books you won't find in corner bookstores and in journals that real people can't access, afford or understand. All professions protect their vested interests through the control information. I see part of my role as liberating this knowledge through translational writing and getting this writing into accessible venues. This month, I will have articles published in peer reviewed scientific journals that will be distributed to several hundred subscribers. Also this month I will have articles published in trade journals that will reach tens of thousands and will also post articles that have the potential of reaching millions of readers. While I have been pushing a recovery research agenda within the scientific community, my recovery journalism is more reflected in the latter types of publication venues.

Mark Sanders: Was what you are describing part of the motivation for creating a web site for your collected papers?

Bill White: Yes, that was the major motivation. And this was not just to make my own papers available but to create a repository where other key papers could be archived on the Internet. I have also used the vehicle of published interviews as a way to transmit knowledge from people in recovery, addiction scientists, addiction treatment leaders and recovery advocates to frontline service providers and to the public at large. The Internet is a magnificent instrument for this liberation of knowledge.

In my early writing career, all my energy was focused on getting published in what I judged to be the best scientific journals in the addictions field. I have less and less interest in that today, and am more interested in my writing reaching people who live outside the doors of this closed club. My peer-reviewed journal writing generates deliverables within government contracts and adds more bricks to the foundation of my professional credibility, but rarely if ever does it change the world in any measurable way. In contrast, I do think my recovery journalism, particularly the translational monographs and articles and recovery advocacy writings, have had some influence on the worlds of addiction treatment and recovery. The website I created was an attempt to extend and sustain influence.

Mark Sanders: What is the biggest surprise you have had since launching your web site?

Bill White: I think the biggest surprise is what the Internet does in terms of extending the sphere of your possible influence. I get a daily report via Google Analytics on how many people visit my web site, which papers they are viewing and downloading, and the frequency of visits from particular countries and cities. It is quite amazing actually. I hoped that many people in the United States would access my papers, but I was totally unprepared for number of visitors from so many other countries. The Internet has a way of making us all neighbors and allowing conversations that would have been unthinkable only a few years ago. For example, I am currently working with Mr. Hossein Dezhakam, leader of a recovery community (Congress60) in Iran, on several projects, and several of my papers have been translated into Farsi. This week I have corresponded with people from a dozen countries. Internet communication is transcending professional, political, religious and cultural barriers in ways we are only just beginning to fathom. To see each day which of my writings is being viewed and downloaded from what countries is an experience I never anticipated.

Mark Sanders: Are we witnessing the beginning globalization of addiction treatment and recovery?

Bill White: That may very well be the case. I have written extensively about the new recovery advocacy movement in the United States, but that movement is rapidly becoming a movement of worldwide dimensions. The Internet is creating the connecting tissue between recovery advocates all over the world and allowing a synergy of ideas and approaches that will accelerate each of the respective national movements.

Mark Sanders: What future plans do you have for your web site?

Bill White: This will be the year that I add video to my site and a photo gallery. Much of my advocacy work has been through the vehicle of words so my site is filled primarily with documents. I will be exploring ways to convey these same ideas and stories visually. At the moment, the site is dense; the visual images should lighten the site and make it a friendlier place for visual learners to visit.

I have also been working on a professional memoir of sorts that is less about me and more about using personal vignettes from the past four decades as a stimulus for self-reflection on the part of the reader. I hope to make progress on editing that in the next two years. We are a field lacking professional memoirs. I hope your students will consider journaling and blogging as worthwhile activities that could evolve into writing professional memoirs in the years to come.

Mark Sanders: What contributions to the field do you still want to make as a writer?

Bill White: I would like to get more of the history of modern addiction treatment and recovery captured in writing and in photographic images before my writing career comes to an end. And I want to get that history deposited on my website so that it is accessible to all. I have tried to contribute to the field in many ways, but I think in the end my ultimate gift to the field will be its own history. I think it is important for your students to each think about the legacy they would like to leave. Legacy thinking affirms that one can make history in small and big ways rather than just existing within it.

Mark Sanders: Thanks Bill. I think my students will find this interview very helpful in thinking about their own future contributions to the field.

About the Authors: Mark Sanders is a member of the faculty of the Addictions Studies Program at Governors State University. William White is a Senior Research Consultant at Chestnut Health Systems.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Remarks at the 2011 Annual Lecture of the Welsh Council on Alcohol and Other Drugs. Posted at **www.williamwhitepapers.com**

Dear Friends of the Welsh Council,

Please accept my deepest regrets that my recent surgery prevents me from being with you tonight and at the annual lecture of the Welsh Council on Alcohol and other Drugs. I am, however, delighted that Phil Valentine, a dear friend and one of our leading recovery advocates in the U.S., will be with you in my stead.

These are exciting and important times. Recovering people and their families and allies are awakening culturally and politically in countries around the globe. That awakening is seen in the growth and diversification of recovery mutual aid societies, the birth and renewal of recovery community organizations, calls for greater recovery orientation in addiction treatment, and challenges to the social stigma that has long constituted a barrier to personal and family recovery. And that awakening is also evident in the rising recovery movement in the UK and in the recent activities of the Welsh Council.

If I was with you tonight, I would pass on three simple lessons from our advocacy work in the U.S. this past decade. The first is simple but profound: there are multiple pathways and styles of long-term addiction recovery, and all are cause for celebration! The second is that recovery is contagious: If you want it, you have to get close to it, catch it, keep catching it and pass it on to others. The third is that personal recovery is precious, but we have to find ways to move beyond our own redemption to heal our wounded families, break intergenerational cycles of addiction and join with others to heal whole communities. Our job is to create the physical, psychological and social space in which recovery can flourish in communities across the globe.

Tonight we stand to put a face and voice on recovery. Tonight we stand to shape the future of recovery. I wish each of you and your families Godspeed on your journey into that future and look forward to the day when I will be with you to witness firsthand the fruits of this work you have begun.

Bill White

Author, *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*

Volunteer, Faces and Voices of Recovery, USA



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2011). Recovery support resources in rural and frontier areas: A call for research and action. Posted at www.facesandvoicesofrecovery.org and www.williamwhitepapers.com

Recovery Support Resources in Rural and Frontier Areas: A Call for Research and Action

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A profound shift is underway in the design of addiction treatment in the United States. The acute care model of biopsychosocial stabilization that dominated addiction treatment over the last four decades of the twentieth century is being revamped via the emergence of models of sustained *recovery management* (RM) and nesting this new approach to addiction treatment and recovery support within larger *recovery-oriented systems of care* (ROSC) (Kelly & White, 2011; White, 2008). RM and ROSC place great emphasis on the development and mobilization of indigenous community resources to support long-term recovery from individuals and families affected by alcohol and other drug (AOD) problems.

As interest in RM and ROSC has grown, questions have arisen about how to design and implement these new models of care and support with particular populations and within particular geographical and cultural contexts. This brief paper explores some of the questions that are arising related to the application of RM and ROSC within rural and frontier settings.

The State of Addiction Treatment and Recovery Support in Rural and Frontier Settings

Concern has existed for some time about alcohol and other drug problems in rural communities (Beltrame, 1978) and how treatment and post-treatment recovery supports can be best delivered within these environments (USDHHS, 1994). A brief review of the professional literature suggests a number of starting points for our discussion.

The Rural Context: The "rural" designation embraces areas with widely differing demographic, economic, and cultural characteristics, including wide variations in AOD-related attitudes and use patterns (Booth & McLaughlin, 2000). Comparing "urban/rural" rural areas (those rural areas containing one or more metropolitan communities) with those areas that have been designated as "very rural" or "frontier" reveal settings with widely differing risks and resiliencies (Fleming, 1994; Leukefeld, Clayton, & Myers, 1992). Rural communities do tend to share some

distinguishing characteristics: individualism, isolation, religiosity, cultural conservatism, distrust towards outsiders, economic distress, and out-migration of young adults (Schoeneberger, Leukefeld, Hiller, & Godlaski, 2006). The risk for substance use disorders in the rural context must be viewed within the growing economic disadvantage resulting from the loss of economic infrastructure, e.g., declines in rural farming, manufacturing, and mining (Schoeneberger, 2006; Schoeneberger et al., 2006). The resolution of substance-related problems must capitalize on the indigenous recovery capital that exists or that can be mobilized within rural areas.

> *We made it* [succeeded in developing an effective rural service delivery model] *because of a willingness to change, to engage the recovering community and the service system, and to work at keeping clear boundaries between ourselves and others. We saw the possibilities as greater than the problems*. (Henderson & Long, 1994)

Problem Prevalence: Living in a rural community is not a protective factor for the development of a substance use disorder (Johnson et al., 2008; Schifano, 2008; Thomas & Compton, 2007), particularly if that rural area includes an accessible medium to large city (Martino, Ellickson, & McCaffrey, 2008). Persons from rural communities tend to present with clusters of drug choices different than those seen in urban areas: alcohol, cannabis, methamphetamine, solvents, and prescription opioids such as Oxycontin (Gfroerer, Larson, & Colliver, 2007; Lambert, Gale, & Hartley, 2008; Stoops, Tindall, Mateyoke-Scrivner, & Leukefeld, 2005). The prevalence of AOD problems in rural communities equals or surpasses those experienced in urban communities (Cronk & Sarvela, 1997; Ruiz, Stevens, McKnight, Godley, & Shane, 2005), and rural youth may even begin AOD use earlier and enter addiction treatment with a greater degree of problem severity than their urban counterparts—particularly in alcohol use and alcohol-related risk behaviors (e.g., drinking and driving) and methamphetamine use (Booth, Kirchner, Fortney, Ross, & Rost, 2000; Hall et al., 2008; Lambert et al., 2008; Pruitt, 2009). The greater degree of problem severity at the time of help-seeking for people living in rural areas may reflect a greater period of delay before seeking help (Fortney & Booth, 2001).

Treatment Infrastructure: Addiction treatment infrastructure in many rural communities is characterized by the recent loss of long-tenured leaders, obstacles to clinical staff recruitment and retention (e.g., professional isolation, limited education/training resources, high caseloads, low salaries), underutilization of the latest clinical technologies, a lack of specialized services (e.g., for women, adolescents, people with AIDS, people with co-occurring disorders), and eroding and unstable funding (Anderson & Gittler, 2005; Clark et al., 2002).

Treatment Access: Barriers to addiction treatment in rural communities include problems related to multidimensional social stigma, lack of treatment availability, lack of payment resources—particularly private insurance, lack of transportation, child care, distrust of service professionals, lack of or exclusive reliance on family/partner/social support for recovery, lack of bilingual staff, lack of integration across service sectors, and perception of inadequate treatment quality by potential referral sources (Booth & McLaughlin, 2000; Metsch & McCoy, 1999; Sawyer, Gale, & Lambert, 2006; Yannessa, Reece, & Basta, 2007). In spite of similar prevalence of substance use problems, rural adults and youth are much less likely to be provided treatment for a substance use disorder than are adults and youth in urban communities (Borders & Booth, 2007; Pullman & Heflinger, 2009; Simmons & Havens, 2007), with some studies finding that drug users in urban areas were twice as likely to enter addiction treatment as drug users in rural areas (e.g., Metsch & McCoy, 1999). Some barriers to treatment entry that have been attributed to rural location may be more

accurately related to other factors, e.g., gender, race, poverty (Small, Curran, & Booth, 2010). Distance—to addiction treatment or a recovery support resource—is a particularly important predictor of access and retention (Beardsley, Wish, Fitzelle, O'Grady, & Arria, 2003).

Treatment Quality: Rural addiction treatment programs, like their urban counterparts, often fail to utilize evidence-based treatment methods (Bouffard & Smith, 2005). While this is reflective of the national state of addiction treatment rather than a uniquely rural issue, there may be particular barriers to disseminating evidence-based practices in rural treatment centers (e.g., professional isolation). Rural programs may have less adjunctive services, culturally specific services, and fewer services for other people presenting with special needs (Bouffard & Smith, 2005). Very little is known about whether and how addiction treatment has been adapted to the special needs of people in rural areas or the extent to which that treatment has been refined for women, adolescents, and other populations that may present with special needs (Booth & McLaughlin, 2000). Private addiction treatment centers in rural areas have added specialized services but are still less likely to offer specialized services for women than private programs located in urban communities (Knudsen, Johnson, Roman, & Oser, 2003). Linkages for post-institutional monitoring, recovery support, and if needed, early re-intervention are particularly weak for rural residents leaving institutional settings to return home to rural areas (Oser et al., 2009).

Treatment Outcomes: In spite of multiple obstacles to availability, access, and acceptance of addiction treatment in rural areas, individuals from these areas who are treated achieve outcomes comparable to those treated in urban communities (Hiller et al., 2007).

The Experience of Recovery in Rural Areas: Only recently have there been studies that sought to capture the lived experience of recovery in rural areas and to extract the implications of those experiences for the design and delivery of addiction treatment and related recovery support services (Grant, 2007).

Indigenous Recovery Support: Little attention has been given in the professional literature on the differences in availability of recovery support resources (e.g., recovery mutual aid meetings, clubhouses, and social activities; recovery homes; recovery advocacy organizations and activities) between urban and rural communities and the effects any such differences exert on long-term recovery outcomes.

Promising Areas of Future Innovation: Promising practices related to the delivery of addiction treatment and recovery support services in rural areas of the United States include:

- service planning on a regional basis that allows geographically contiguous rural areas to create and sustain recovery supports jointly that would be beyond the resources of each contributing partner (Fleming, 1994);
- delivery of addiction treatment services through rural satellites, co-location with existing health and social service resources and assertive outreach programs (White, 2009);
- delivery of addiction treatment services through training of medical or mental health specialists (particularly for women; Booth et al., 1999);
- delivery of services via bibliotherapy (letters, books, manuals, pamphlets);
- assertive models of case management that assure consistency and continuity of support—particularly for rural women (Kopelman, Huber, Kopelman, Sarrazin, & Hall, 2006; Passey, Sheldrake, Leitch, & Gilmore, 2007; Vaughn-Sarrazin, Hall, & Rick, 2000);
- telephone (including text-based interventions and smart phone applications), videoconferencing and Internet-based

treatment/support (including potential development of applications for iPad, Kindle and other E-reader platforms) (Finfgeld-Connett & Madsen, 2008; Kavanagh & Proctor, 2011; Miller, 2005);

- use of community organizer roles (versus clinical roles) to develop and mobilize indigenous recovery support resources within rural areas (White, 2009); and
- application of the concept of "community recovery" to the long-term resolution of AOD problems in rural areas (White, Evans, & Lamb, 2010; Willie, 1989).

Resilience and Recovery in Rural Areas

Two things are striking from the above brief review. First, rural areas have been viewed primarily through the lens of their deficits rather than their assets. Second, we know a lot more about addiction and addiction treatment in rural areas than we know about addiction recovery in these same milieus. The lack of focus on recovery in all addictions-related research and this absence extends to rural research. In 1996, a group of drug use(r) researchers interested in "rural and urban research and practice" met in Lexington, Kentucky, to formulate research questions related to AOD problems in rural areas. The meeting generated more than 60 important research questions—not one of which was specifically related to long-term recovery. In fact, the word *recovery* does not appear in the conference report (Leukefeld & Edwards, 1999).

Significant advantages could accrue from focusing on existing and potential recovery support assets in rural communities. The focus on indigenous recovery resource development closely aligns with the rural reliance on family, extended family, social networks, and indigenous institutions (e.g., churches, co-ops) to solve problems rather than relying on service professionals (Metsch & McCoy, 1999). Restricted and potentially diminishing access to professionally-directed addiction treatment may be overcome by people seeking recovery in rural communities via support from family, friends, primary care physicians, clergy and faith communities, work, school, and through local and online recovery support groups (Grant, 2007). And addiction recovery may provide a context for the recreation of community in response to the weakening of mutual identification and support that has long characterized rural areas but that has weakened in recent decades (Grant, 2007).

Shifting the lens through which we examine rural areas from a pathology or intervention (treatment) paradigm to a solution-focused recovery paradigm is hampered by the lack of recovery-focused research in rural areas. The goal for the future is addiction recovery support services in rural communities that are available, accessible, affordable, and acceptable. Achieving that goal will be greatly facilitated by answers to key questions related to the current state of addiction recovery in rural areas and on the design, delivery, and evaluation of recovery support services in rural communities. Below are some of the questions that would be part of this rural recovery research agenda.

Recovery and the Rural Context

- How are the changing demographics of rural areas (e.g., aging of the rural population, racial diversification, etc.) affecting needs of addiction treatment and recovery support services?
- How do social norms related to alcohol and drug use in rural areas affect availability of addiction treatment and recovery supports and the experiences of people seeking recovery within these areas?
- Do the obstacles related to stigma faced by people in recovery differ for people living in rural areas?

Prevalence of Recovery

- What is the prevalence of recovery within rural areas of the United States (e.g., what percentage of people in rural communities who meet lifetime DSM-IV criteria for a substance use disorder do not meet such criteria for the past year)?
- Does the prevalence rate (in remissions per 100,000 people meeting lifetime diagnostic criteria) vary by degree of rurality?
- What is the demographic/clinical profile of those who recover and those who do not recover within rural areas?
- How is the rate of recovery prevalence changing over time within rural areas?

Process of Recovery

- What are the factors most related to recovery initiation among people living within rural areas?
- What is the global health status of people in recovery within rural areas and how does this status change over the course of recovery? Are there particular recovery service/support needs of people in rural areas that are stage-dependent?

Barriers to Recovery

- What barriers to recovery are unique to rural areas?
- What are the most common mistakes made in attempting to deliver treatment and recovery support services to rural areas?
- What strategies have been proven to be most effective in overcoming barriers to recovery in rural areas?

Recovery Supports

- What is the degree of availability, accessibility, affordability, and varieties of addiction treatment and recovery support services in rural areas of the U.S.?
- What are the most effective strategies for elevating the use of evidence-based, recovery-focused treatment practices in rural areas?
- What is the availability of recovery mutual aid societies within rural areas, and are these resources increasing or decreasing?
- What are the choices of recovery mutual aid societies available to people living in rural communities (e.g., varieties of 12-Step fellowships; varieties of secular and religious alternatives to 12-Step fellowships; availability of specialty groups related to age, gender, sexual orientation, medication status, etc.)
- Does participation in known active ingredients of 12-Step programs (e.g., meeting participation, step work, service work) differ in rural and urban areas?
- What family recovery support services exist in rural areas?
- What recovery support institutions exist in rural areas beyond recovery mutual aid fellowships, e.g., recovery community organizations, recovery centers, recovery homes, etc.?
- What creative strategies are emerging to address the transportation needs of people seeking recovery support services in rural areas?
- Could family and friends within rural areas be trained to perform some of the functions now being delivered by recovery coaches in urban communities?
- What are the effects of telephone- and internet-based recovery

support services on long-term recovery outcomes among people living in rural areas, e.g., the Online Recovery Network of the Heartview Foundation in Bismarck, North Dakota?

- What are the effects of cultural revitalization approaches (e.g., methods used by White Bison) on long-term recovery outcomes within rural communities? How might such approaches be more widely replicated?

Intrarural Variations

- What differences exist related to the above questions across rural areas and by the degree of rurality?
- What differences exist related to the above questions within particular ethnic and cultural rural communities, e.g., Native American communities, migrant communities?
- How do the pathways and processes of addiction recovery differ within rural areas across special populations of residents, women, adolescents, people recovering from co-occurring disorders, people re-entering the community from prison, Native American communities, etc.?

A Starting Proposal

The incremental process through which science proceeds will make it very difficult to quickly extend pathology-focused and treatment-focused addiction research to encompass a focus on the pathways and processes of recovery—particularly studies focusing on recovery in rural areas of the United States. I am not expecting National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism funding for such research to appear on the horizon any time soon, but there are preliminary steps that could be taken. Recovery prevalence questions could be added to existing studies on the epidemiology of AOD use and AOD-related disorders that would shed light on the rural recovery prevalence question. Studies of post-treatment monitoring and support models pioneered in urban communities (Scott, Dennis, & Foss, 2005) could be tested for comparability of outcomes in rural communities. Additionally, there is a need to mine the growing base of experiential knowledge related to the delivery of recovery support services in rural areas through projects like the Center for Substance Abuse Treatment's Recovery Community Service Program (RCSP) and the Access to Recovery (ATR) program. Representatives from the RCSP and ATR programs (particularly those from designated rural and frontier states) could be brought together to capture their experience on key recovery-related questions and to formulate specific questions that could help shape a rural recovery research agenda. This could be accomplished through a centralized gathering or hosted in key rural regions via the Addiction Technology Transfer Network. It is time such preliminary steps were taken.

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Acknowledgement: Support for development of this paper was provided through a cooperative agreement with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). All material appearing in this paper except any taken directly from copyrighted sources is in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the author. Citation of the source is appreciated. Do not reproduce or distribute this publication for a fee without specific, written authorization from the Great

Lakes Addiction Technology Transfer Center. The opinions expressed herein are the views of the author and do not necessarily reflect the official position of SAMHSA ir CSAT.

The author would like to express appreciation to Betty Currier, Kurt Snyder and Kathy Jo Stence for providing helpful feedback on an early draft of this paper. Stephanie Merkle assisted in the final editing of the manuscript.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Garner, B. (2011) Staff turnover in addiction treatment: Toward science-based answers to critical questions. *Counselor*, 12(3), 56-59. Posted at **www.williamwhitepapers.com**

Staff Turnover in Addiction Treatment: Toward Science-Based Answers to Critical Questions

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Workforce development in the addiction treatment industry includes the duration, breadth, and depth of preparatory education people receive before entering the treatment field; the screening, selection, orientation, and ongoing training and supervision process; and the circumstances under which addiction professionals end their tenure within a particular organization and the larger field. Given the status of staff turnover as one of the key performance measures related to workforce development (Kaplan, 2003), it is surprising how few scientific studies have been conducted on its prevalence, patterns, effects, and remediation strategies. This paucity is surprising in light of the potentially profound effects this issue exerts on the quality of addiction treatment and the quality of work life in addiction treatment organizations. The purpose of this article is to give addiction professionals a thumbnail sketch of what is being learned about staff turnover within recent scientific studies.

What are the different types of staff turnover?

Defining staff turnover in addiction treatment would seem a relatively simple task, but the precise meaning and consequences of someone leaving an organization may be hard to interpret. People leave positions in addiction treatment under voluntary (employee-initiated) and involuntary (employer-initiated) circumstances, and even these categories may be hard to interpret. For example, voluntary resignation may include factors such as family circumstances that have nothing to do with the work place per se, and involuntary termination may span discharge for performance issues, supervisor-supervisee personality conflicts, and layoffs due to budget cuts or even program closure (Gallon, Gabriel, & Knudsen, 2003). Staff turnover may be viewed as desirable or undesirable depending on the level of performance of the person leaving. Individual counselors exert a significant effect on clinical outcomes (McLellan, Woody, Luborsky, & Goehl, 1988). Such responses to addiction treatment and to a particular addiction counselor span optimum benefit, partial benefit, no measurable effects, or harmful effects. Losing counselors whose clients consistently achieve optimum benefits is a much different situation than losing counselors whose clients consistently experience minimal or harmful effects.

Finally, it is important for us to distinguish between organizational turnover and occupational turnover—a person leaving a particular organization versus a person leaving the field of addiction treatment.

So, do we know the nature of such patterns in the addictions field? Studies to date suggest three tentative findings. First, a substantial portion of addiction counselors (22.4%) and clinical supervisors (31.8%) who leave treatment organizations do so involuntarily; 15.1% of exiting counselors and 15.9% of exiting clinical supervisors are terminated (Eby, Burk, & Maher, 2010). Second, most addiction counselors (64%) and clinical supervisors (89%) who leave an addiction treatment organization remain working in the addictions treatment field (Eby et al., 2010). Third, in contrast to this high level of commitment to the field, some studies note high (e.g., 76%) intention of addiction counselors to leave their current position or organization in the next five years (Evans & Hohenshil, 1997).

Although 36% of counselors turning over are leaving the field (Eby et al., 2010), we do not know at this point in time, and need to know, whether we as a professional field are losing our most or least effective addiction counselors. Without such data, it is impossible to know what portion of staff turnover represents a significant problem for the field and what portion represents the field's effort to resolve problems of ineffectual or harmful professional performance. The data we do have available suggest potential indicators of widespread problems related to staff screening, recruitment, training, and supervision as well as the potential prevalence of person-field mismatch, person-organization mismatch, and person-role mismatch—mismatches that all exert a potentially significant effect on clinical outcomes and organizational health.

What is the rate of staff turnover in the addiction treatment field?

Most of the figures on staff turnover in addiction treatment are based on surveys of administrators who estimate annual turnover (Gallon et al., 2003; Knudsen, Ducharme, & Roman, 2006; McLellan, Carise, & Kleber, 2003; McNulty, Oser, Johnson, Knudsen, & Roman, 2007), with such rates varying across reports from 16% to 57%. Such variation is compounded by studies of different sectors (private vs. public programs), different regions of the country, varying scopes (counselors only versus all staff), different formulas for calculating turnover, and the rather amazing lack of longitudinal studies of actual staff turnover in addiction treatment (Eby et al., 2010).

A recent and well-designed study by Eby and colleagues (2010) examined turnover rates over a two-year period within 27 geographically dispersed addiction treatment organizations in the United States. The average annual turnover rate within these sites was 33.2% for counselors and 23.4% for clinical supervisors—rates substantially higher than the 19.6% annual turnover rate reported by the Bureau of Labor Statistics for all health and human services and the rates reported for nurses (12%) and teachers (12%, comparison rates cited in Knudsen, Johnson, & Roman, 2003). Such comparisons provide objective confirmation of the instability of the addiction treatment workforce—an instability key leaders see as reflecting broader organizational and leadership instability within the field (McLellan et al., 2003).

What is less clear is how turnover rates vary across counselor demographics (e.g., age, gender, race, education, certification, recovery status), geographical areas of the country, treatment modalities and levels of care, caseload size, clinical populations (e.g., adolescent versus adult services, caseload type such as percentage with prior treatment or criminal justice involvement), other direct service roles (e.g., physicians, nurses, case managers, outreach workers, recovery coaches), and non-treatment organizational units (e.g., prevention, research, training, administration). Also unclear is the benchmark rate of annual turnover that could be used by organizations and organizational units to measure their relative stability and health. If prolonged low turnover (a potential indicator of closed incestuous organizational

systems) and persistent high turnover (a potential indicator of low cohesion and weak organizational cultures) both signal potential problems of organizational health (White, 1997), what is a normal and even desirable level of annual turnover within addiction treatment organizations? The only preliminary answers to such questions are that:

- Addiction counselors working in hospital settings report a lower intention to leave than staff working in other community settings—a factor likely linked to salary differentials across the two settings (Rothrauff, Abraham, Bride, & Roman, 2010).
- Younger staff and male staff have been found to have higher rates of burnout (work-related emotional distress and depletion), which may influence intention to quit and subsequent turnover (Garner, Knight, & Simpson, 2007).
- Lower rates of turnover are associated with four linked factors: professional certification, age, tenure in the organization/field, and higher salaries (Knudsen, Ducharme, & Roman, 2008; Knudsen, Johnson, & Roman, 2003; Mulvey, Hubbard, & Hayashi, 2003; Rothrauff et al., 2010). Minority status is also associated with a lower level of turnover among addiction counselors (McNulty et al., 2007).
- The status of recovery predicts a higher commitment to the field, but not necessarily a higher commitment to a particular organization (Curtis & Eby, 2010; Knudsen et al., 2006; Rothrauff et al., 2010).
- Being female, having a graduate education, and being in recovery are all associated with higher rates of turnover among counselors working in addiction treatment (McNulty et al., 2007).
- There is a high reported turnover of program directors, with more than half of directors reporting in one survey that they had been in their current position less than one year (McLellan et al., 2003).

The limitations of these early studies and their lack of replication make it difficult to draw definitive conclusions and implications. Furthermore, acknowledging the demands of working as an addiction counselor and global problems in workforce development in the addictions field may obscure the fact that surveyed addiction counselors report high rates of overall personal satisfaction with their work and low rates of burnout (Broome, Knight, Edwards, & Flynn, 2009).

What factors contribute to turnover in addiction treatment organizations?

Staff turnover within addiction treatment organizations can occur in the best workplace conditions (e.g., greater outside professional/financial opportunities), the worst conditions (e.g., dissatisfaction, emotional distress, inadequate performance, breaches in ethical conduct), and in conditions unrelated to the workplace (e.g., illness, pregnancy, retirement, disability, death).

The best single predictor of future staff turnover is, not surprisingly, self-reported intention to quit (Griffeth, Hom, & Gaertner, 2000). The most recent study of intention to leave an organization (Rothrauff et al., 2010) found less than 8% of addiction counselors expressing intent to leave the field of addiction counseling. The major organizational factors contributing to intention to quit within addiction treatment institutions include perceived:

- ambiguity or organizational mission (Garner et al., 2007; Knudsen, Ducharme, & Roman, 2009),
- inadequacy of salaries and benefits (Knudsen et al., 2003),
- inadequate frequency and quality of clinical supervision (Knudsen et al., 2008),

- lack of access to training and professional development (Eby et al., 2010),
- excessive caseloads and paperwork (Broome et al., 2009),
- lack of autonomy and control (Knudsen et al., 2003, 2006, 2008),
- unfairness of supervisory/administrative decision-making (Knudsen et al., 2008), and
- role-person mismatch and other work-related stressors (e.g., role overload, role ambiguity, role conflict) (Eby et al., 2010; White, 1997).

Limiting our understanding of the dynamics surrounding intention to quit and subsequent turnover is the fact that most studies have been conducted in settings (e.g., private treatment programs, clinical research sites) that may not be typical of conditions and circumstances in most addiction treatment programs. Similar studies are needed of differences in turnover rates across the field's diverse practice settings. Much more knowledge also is needed on how intention to leave a treatment agency is influenced by such worker characteristics as age, race, gender, education, certification, and recovery status and by such work environment factors as salary and benefit levels, supervision, organizational culture, particular role stressors, and caseload size and type.

What are the consequences of staff turnover?

The literature on staff turnover in addiction treatment consistently alludes to potential negative effects of staff turnover on clients and the financial costs of staff turnover related to recruitment, hiring, and training of new staff and lost billings associated with open staff positions. In spite of such consistent references, we found no studies that actually reported data on the existence, nature, or degree of harm experienced by clients as a result of staff turnover or quantified financial costs of turnover in the addiction treatment setting. Also missing are studies reporting the effects of staff turnover on other members of the treatment team, (e.g., emotional distress, increased workloads, intentions-to-quit). The decision to leave an organization is a highly personal one, but also may flow out of larger processes within the organization. We have observed many organizations with a stable workforce go through a period of organizational turmoil characterized by a contagion of demoralization and mass turnover. These larger processes and their effects on the health and performance of staff and clients also have not been studied. However, the most critical questions related to staff turnover in addiction treatment regard its effects on clients and families being served. We need to know if there are such effects, the nature and severity of such effects, and strategies though which such effects can be ameliorated.

What strategies can be used to help prevent staff turnover?

Most of the strategies recommended to reduce staff turnover in addiction treatment are derived from the studies that identify correlates of high intentions–to-quit and high rates of turnover rather than from controlled experiments that test the effectiveness of different strategies. A 2003 survey of treatment administrators generated recommendations to reduce staff turnover that included increasing salaries, improving benefits, reducing paperwork, providing ongoing training, providing personal recognition, enhancing career development, and shortening working hours (Gallon et al., 2003). Studies of broader organizational factors linked to turnover also note that:

- Participatory management practices enhance organizational commitment, which in turn fosters counselor retention (McNulty et al., 2007).
- Administrative support and clinical supervision enhance retention by reducing burnout, increasing job satisfaction, and increasing

organizational commitment (Broome et al., 2009; Knudsen et al., 2003).

- Management practices linked to enhanced staff retention include long-term strategic planning, decentralized decision-making, and the presence of non-tangible rewards (Knudsen et al., 2003, 2009).

Conclusions

Implications drawn from scientific studies of staff turnover in addiction treatment are suggestive and offer starting places for action by program administrators and supervisors, but from the standpoint of science we do not know what strategies work best in particular types of treatment settings and with particular types of staff. We believe it is time for researchers to provide definitive answers to two of the most critical turnover-related questions within the addictions field:

> 1) What are the effects of staff turnover on the treatment outcomes of clients and their families?
> 2) What are the best strategies and/or interventions to reduce the high rates of staff turnover?

Fortunately, research is currently underway to address these questions. Indeed, the National Institute on Drug Abuse just recently funded a three-year study entitled "Impact, Predictors, and Mediators of Therapist Turnover." This will be the first known study to quantify the impact of staff turnover on quality of care and client outcomes. Upon the completion of this study, we look forward to sharing the results and their implications with the readers of *Counselor*.

As a final note, we believe it also might be of benefit for the field to shift its focus from why counselors and other addiction professionals leave employment in addiction treatment to why people stay working within particular organizations and within the field. Ironically, while there is much to learn about staff turnover, we know a lot more about turnover than we know about retention. A balanced approach of problem- and solution-focused studies would likely not only enhance the quality of addiction treatment, but also enhance the quality of work life for addiction professionals.

Acknowledgment: Preparation of this paper was supported by grant award R01-DA030462 from the
National Institute on Drug Abuse (NIDA), grant award R01-AA017625 from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and contract number 270-2003-00006 from the Center for Substance Abuse Treatment (CSAT).

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Follow-up studies of addiction treatment confirm the generally positive effects of acute treatment episodes, but these same studies also document wide variability in post-treatment adjustment and the erosion of treatment effects over time. Studies of the potentially prolonged course of severe alcohol and other drug (AOD) problems (sometimes referred to as "addiction careers") combined with studies confirming the high rates (more than 50%) of resumed AOD use following treatment and high rates of multiple treatment admissions (64% of all patients entering treatment) have produced two significant shifts in the field. The first is a more clinically sophisticated conceptualization of addiction as a potentially chronic disorder (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000; White & McLellan, 2008); the second is a call to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (White, 2008).

Recovery management calls not for larger doses of traditional services, but earlier and sustained intervention using assertive outreach methods to keep patients engaged. In particular, the model extends the duration of post-treatment recovery support services, intensifies those services during windows of initial and subsequent vulnerability, and moves the locus of recovery support from the treatment environment to the natural environment of the patient (White & Godley, 2003). A distinguishing feature of recovery management is its emphasis on post-treatment monitoring, support, and early re-intervention as continuing care/recovery management strategies (Kelly & White, 2010).

This article will 1) review the state of continuing care following addiction treatment in the U.S., 2) summarize the findings of a randomized controlled trial of telephone-based continuing care, and 3) discuss emerging and future innovations in continuing care.

The State of Continuing Care

A review of research studies (White, 2008) related to the need for and effects of continuing care following addiction treatment leads to five primary conclusions.

1. People discharged from addiction treatment are precariously balanced

between continued recovery and resumption of AOD use.

2. The risk of resumed AOD use is highest in the first 90 days following completion of treatment, but the risk of future lifetime relapse does not subside below 15% until one reaches 4-5 years of sustained recovery (Jin, Rourke, Patterson, Taylor, & Grant, 1998).
3. Continuing care in the form of post-treatment monitoring and support can enhance long-term recovery outcomes in both adults (Scott, Dennis, & Foss, 2005; McKay et al., 2010) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2007; Kaminer, Burleson, & Burke, 2008).
4. Practices related to post-treatment continuing care vary widely across treatment programs, but national data reveal that only a small percentage of patients admitted to treatment receive structured, intensive, and sustained post-treatment support.
5. Many addiction treatment programs rely almost exclusively on participation in recovery mutual aid groups to support their patients in the transition from recovery initiation to recovery maintenance, but this strategy is undermined by low rates of linkage/affiliation and high rates of attrition over time.

The lack of sustained monitoring and recovery support services in contemporary addiction treatment programs and the resulting consequences in terms of compromised recovery outcomes have led to calls for assertive approaches to continuing care. These approaches:

- encompass all admitted patients/families, not just those who “successfully graduate”;
- place ultimate responsibility for post-treatment contact with the treatment institution, not the patient;
- provide continued support in a mix of professional and peer-based formats;
- involve both scheduled and unscheduled contact;
- capitalize on temporal windows of vulnerability (e.g., the first 90 days following treatment) and increase monitoring and support during later periods/situations of heightened vulnerability identified by each patient;
- individualize and vary the duration and intensity of checkups and support based on each patient’s changing problem severity and recovery capital (personal and environmental resources to prevent relapse and build a rewarding life free of alcohol and other drug use);
- utilize assertive linkage rather than passive referral to communities of recovery;
- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support, and a growing array of internet-based resources;
- emphasize support contacts with patients in their natural environments;
- may be delivered either by counselors, recovery coaches, or trained volunteer recovery support specialists; and
- emphasize continuity of contact and service (rapport building and rapport maintenance) in a primary recovery support relationship over time.

Studying assertive approaches that rely on lower-cost telephone- and internet-based interventions is critical since sustaining the above-described approaches can be costly, particularly if done on a face-to-face basis over an extended period of time.

Testing the Effectiveness of Telephone-Based Continuing Care

Several researchers have suggested the untapped potential of telephone-based continuing care following addiction treatment (See McKay, 2009 for an excellent review). In addition to being less costly to deliver, telephone-based approaches offer several potential advantages to patients, including

- convenience (less disruption to daily life),
- cost (no travel or child care),
- safety (for patients in high-risk environments),
- accessibility (reaching patients in remote areas or who face transportation challenges),
- adaptability (varying length of contact based on patient need at moment of contact),
- timing (either patient or support worker can initiate calls at or around high-risk times or places if GPS-enabled smartphones are used), and
- amplification effects (e.g., combining telephone-based support with face-to-face meetings to strengthen therapeutic alliance, lower dropout rates, and enhance recovery outcomes).

A recently published study tested the potential effectiveness of telephone-based continuing care following addiction treatment (Godley, Coleman-Cowger, Titus, Funk, & Orndorff, 2010). In this study, 104 adult patients were randomly assigned to either usual continuing care (UCC) consisting of weekly outpatient gender-specific group counseling facilitated by a master's level clinician, or telephone continuing care (TCC) consisting of weekly telephone support provided for a 90-day period by a paraprofessional staff member or volunteer with a bachelor's degree in a human service field. To make sure that those who left residential treatment prior to program completion had the opportunity to participate in continuing care, informed consents to participate in the study and random assignment to condition were completed during the first week of residential treatment.

The study participants averaged 31.6 years of age, were predominately male (60%) and Caucasian (76%), with high problem severity (85% meeting criteria for alcohol, cannabis, cocaine, or opioid dependence), high problem complexity (78% reporting symptoms consistent with one or more co-occurring mental disorders) and chronicity (63% reporting use before age 15; 64% reporting prior addiction treatment). The average length of treatment for the study population was 24 days and 86.5% successfully completed residential treatment. The only significant difference between those assigned to UCC and TCC was a higher rate of use and physiological dependence by the TCC group. Paraprofessional staff and volunteers working within the TCC condition made weekly 10- 20-minute calls following a standard protocol that prescribed both the content (review of recovery status and recovery support activities, problem solving, and recovery planning) and tone/style (supportive, non-confrontational) of the call. Fidelity to the TCC protocol was monitored through audio-recording of calls and a review of random tape recordings during weekly supervision.

Outcomes across the two conditions were measured by use of the Global Appraisal of Individual Needs (GAIN), self-reported days abstinent and substance problem behaviors at 3 and 6 months post-discharge, as well as urine screening and patient satisfaction with the TCC condition. There were three major findings from this study.

1. Those assigned to the telephone continuing care group were significantly more likely to receive continuing care sessions compared to those in the usual continuing care, face-to-face, group-based format.
2. At the 3-month follow-up, the TCC condition had significantly fewer substance-related problems, and a comparison of lower severity patients showed even more improvement in both increased days of abstinence and

decreased substance-related problems. Because this was a short-term feasibility trial, the continuing care support calls were stopped after 3 months and statistically significant improvements for the TCC condition were no longer present at the 6-month follow-up. These findings are encouraging but suggest the need for longer duration of continuing care calls.

3. Most (89%) of the patients participating in the TCC condition liked receiving the calls from their telephone support counselor and felt the time spent on each call was "just right" (91%). Most importantly, patients felt the calls should be extended beyond 3 months (72%).

The Future of Continuing Care Following Addiction Treatment

If there is a new frontier of addiction treatment, it is in extending the effects of treatment through assertive and other innovative approaches to sustained recovery management for months and years following recovery initiation. There seems to be unlimited potential in the use of new technologies of recovery support to achieve this goal. We anticipate the dramatic growth of telephone- and internet-based recovery support services in the near future. For example, there are already continuing care/recovery support applications for smartphones that will link patients to a listserv, allow them to assess their risk and protective factors in real time, and to request a call from a recovery support counselor (Gustafson et al., 2011). Another recent innovation is to hold continuing care groups on Second Life where both patients and therapist come together at a designated time via their personal avatar (Dillon, 2010). It is important that these and future developments are guided by methodologically sophisticated studies that can evaluate their degree of effectiveness across demographic and clinical populations, with an emphasis on understanding which subgroups of patients may benefit from which approaches. For example, in the present study, we found that lower severity patients may have benefitted more than those with higher severity. Future studies should also focus on whether telephone and other technologically sophisticated approaches remove known service access disparities for special populations (e.g., rural and remote populations).

In this shift from acute stabilization to recovery maintenance and enhanced quality of personal/family life in long-term recovery, there are a number of very important unanswered questions, including:

- How can the "active ingredients" of these recovery support services be isolated, amplified, and combined or sequenced to enhance long-term recovery outcomes?
- How can the emerging recovery support technology be individualized to respect patient preferences and optimize clinical effectiveness?
- How long should such services be provided, can we reliably maintain longer-term contact with most patients, and what role do patient preferences play in successfully achieving optimal duration of service?
- By whom are these services best provided (professional versus peer models) and through what type of organizational settings (e.g., addiction treatment organizations, managed behavioral health care organizations, grassroots recovery community organizations)?
- What financing models will support the growing emphasis on sustained recovery management services?

Answering such questions will require the deep involvement of addiction professionals, addiction researchers, and listening carefully to the voices of individuals and families spanning multiple stages of long-term recovery. Many addiction professionals are stepping forward to explore this new frontier, and their practice and research will define

the future direction of long-term addiction recovery management and support.

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Acknowledgement: The research for this paper was supported in part by the National Institute on Alcohol Abuse and Alcoholism grant 2 R01 AA010368. This paper was supported in part by SAMHSA contract HHSS28320070006I Westat Subcontract s8440, Recovery Supports for Adolescents and Families. The views expressed in this paper are the authors and do not necessarily reflect the views or policies of the Department of Health and Human Services.

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Citation: Evans, A. C., Heriza, J. G. & White, W. L. (2011). A photographic essay--the art of recovery in Philadelphia: Murals as instruments of personal and community healing.
Posted at **www.williamwhitepapers.com**

The Art of Recovery in Philadelphia: Murals as Instruments of Personal and Community Healing

Arthur C. Evans, Jr., PhD, Jane Golden Heriza, and William L. White, MA

In 2004/2005, a series of citywide focus groups on behavioral health service needs sparked what came to be christened "the recovery revolution in Philadelphia" (White, 2007). This fundamental redesign of behavioral health care involved an expansion of peer recovery support resources, a shift in professional treatment emphasis from acute stabilization to long-term recovery support, and the mobilization of individuals and families in recovery as a cultural force for personal healing and community renewal (Achara-Abrahams, Evans, & King, 2011).

This redesign process, which has made the city of Philadelphia a beacon of hope and model of systems transformation in behavioral health care, has been guided by several foundational principles (Evans, 2008).

- Individuals and families who have been historically defined as part of their community's "problem" can be engaged to become a healing force ("recovery carriers") within these same communities.
- Communities can themselves become wounded and in need of a recovery process.
- Personal, family, and community recovery are inextricably linked; effective recovery strategies must touch all of these levels and affect their interrelationships.
- Building personal, family, and community "recovery capital" requires creative approaches that counter imbedded hopelessness and resignation and stir hope and regeneration (White, Evans, & Lamb, 2010).

Community recovery has been defined as a voluntary process through which a community uses the assertive resolution of alcohol and other drug-related problems as a vehicle for collective healing, community renewal, and enhanced intergenerational resilience. Community recovery is more than the personal recovery of community members; it involves strengthening the connective tissue

between those with and without such problems while restoring and sustaining the quality of community life (White et al., 2010).

This article explores how art has emerged as a unique strategy to promote personal, family, and community recovery and health in the city of Philadelphia. More specifically, it reviews the history of the Philadelphia Mural Arts Program, highlights the Mural Arts Porch Light Initiative, and describes how the mural development process has served as a catalyst for personal change and community renewal.

The Philadelphia Mural Arts Program

The Philadelphia Mural Arts Program was founded in 1996 as an outgrowth of the Philadelphia Anti-Graffiti Network (PAGN), which was established by the City in 1984 to work with youth arrested for graffiti or other minor crimes. The early vision of the PAGN was to channel the abilities of graffiti artists into projects that would elevate rather than deface the community. Since that time, the broader Mural Arts Program has involved thousands of artists and citizens in the creation of more than 3,000 murals that now grace the Philadelphia landscape and draw tourists from around the world. The mission of the Mural Arts Program is to “unite artists and communities through a collaborative process, rooted in the traditions of mural-making, to create art that transforms public spaces and individual lives.” The Mural Arts Program is overseen in part by the city of Philadelphia and in part by a 22-member board of directors.

The Mural Arts Program engages with more than 100 Philadelphia neighborhoods each year and also works with adult and juvenile correctional institutions to include adults and youth returning to the community in mural projects. The themes that permeate these murals range from celebration of cultural heritage to day-to-day community life. The murals collectively celebrate intergenerational family relationships, health, work, learning, sport, artistic achievement, public service, faith, community character, and resilience. The images are ones that inspire, expand possibilities, and elicit wonder, as well as honor and connect people.











The Mural Development Process

The process used to create the murals is as important to the city of Philadelphia and its neighborhoods as the resulting artwork. Each completed mural represents a prolonged three- to six-month process of engagement between the lead artist, community leaders, and neighborhood residents. Every effort is made to ensure that murals are available to Philadelphia's diverse cultural communities. The process starts with a mural application since the demand for murals now exceeds available funding for these projects. Selection of successful applicants is followed by recruitment of a muralist whose unique background and skills best match the vision for the mural that has emerged from the community engagement process. This is followed by finalization of the mural location, dialogue with the community to further develop ideas for the mural, and formalization and implementation of the final mural plan.

The Mural Arts Program also is involved in mural development projects with adult and adolescent men and women at correctional facilities in the Philadelphia area, including The State Correctional Institution at Graterford, Riverside Correctional Facility for women, Curran-Fromhold Correctional Facility, the House of Correction, Philadelphia Industrial Correctional Center, Philadelphia Youth Study Center, St. Gabriel's Hall, and VisionQuest. Programs within these facilities are designed as vehicles of restorative justice through which inmates and youth are afforded opportunities through volunteer service in the arts to make amends to their communities.

Philadelphia's mural projects are rendered in diverse media: paint, glass, tile, woven tapestries, and sculpture. The finalized image of the mural moves from the artist's sketch to the building wall through one of four methods: 1) a grid system (through which the original image is divided into sections that are each then replicated in larger relief on the wall), 2) photo transfer (through which a photo of the original image is projected onto a wall, traced, and then rendered with paint and other materials), 3) stencil tracing (to outline the image and guide the artist), and 4) tracing of a projection on the wall. Volunteers are often engaged in the actual mural creation process. From start to finish, the Mural Arts staff work with local community organizations to host events (workshops, symposia, town meetings) to discuss and seek consensus on issues related to the central themes to be conveyed through the mural and to mobilize community action (Voices of Community, ND).









The Healing Power of Art

Through the mural development process—from application and conception to celebration of the completed mural—old relationships are renewed and new relationships are formed between people whose lives might otherwise never have intersected. The result is a healing web of community support and a community more connected and empowered to care for its own and to help fulfill the personal

destinies of its members. Jane Golden Heriza, Founder and Director of the Mural Arts Program, describes the power of this process as follows:

> *Murals work on a symbolic level, providing opportunities for communities to express important concerns, values and aspirations—their yearning to be free of violence and fear, their hopes for a better world, their desire for beauty. The murals also become catalysts for social change. Murals bring together residents to not only work on the design for the mural, but to discuss and implement strategies for neighborhood transformation. Murals can help bring residents together to create community pride, and catalyze community involvement in activities that range from block clean-ups to garden and art education programs for the young* (Heriza, ND).















Early Behavioral Health Murals

The first Mural Arts Program projects that explicitly conveyed behavioral health themes were completed in 2008 and 2009. These murals, which were precursors to the launch of a special behavioral health mural initiative, are described and visually portrayed below.

Project: Recovery and Transformation
Theme: Recovery from mental health issues
Completion Date: July, 2008
Partners: Elwyn Institute, Wedge Center, Community Council, Path Center, COMHAR Center, Horizon House, and inmates from SCI Graterford Prison.
Artists: Eric Okdeh, assisted by David Gray and Desiree Bender **Poet:** Angela Crafton
Location: Elywyn Institute – 4040 Market Street

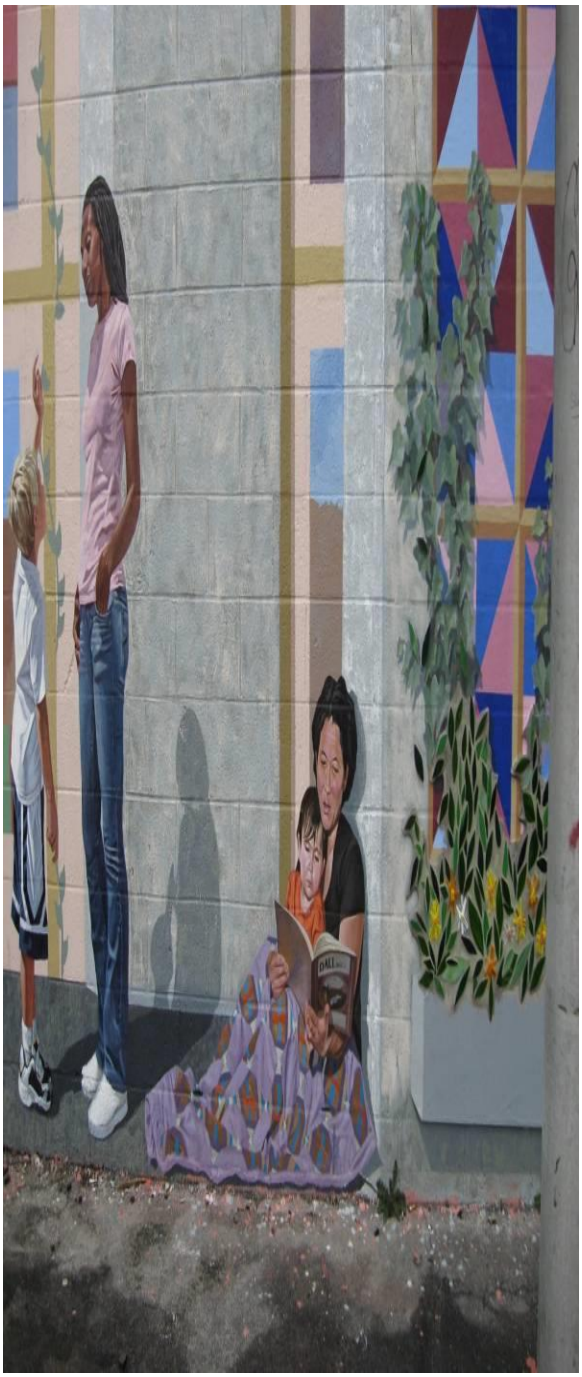


Project: Bridging the Gap
Theme: overcoming conflict, accepting commonalities and differences, and healing.
Completion Date: April, 2008
Partners: ACANA (African Cultural Alliance of North America), Chester Avenue Business Association, Southwest CDC
Artists: Willis Humphrey, with special assistance by Twins Seven Seven
Location: Southern Inn Restaurant, 5741 Woodland Avenue



Project: Keeping Kids Safe

Theme: Children's needs for caring, responsibility, and participating in activities in safe environments.
Completion Date: June, 2009
Partners: Newbold Civic Association; representatives for the Department of Behavioral Health; the staff of Guerin Recreation Center; residents of the community; participating students from Mural Arts AVRP (Adolescent Violence Reduction Program) sites at Lutheran Family Services, Carson Valley School, Mothers in Charge, Diversified Community Services, Norris Square Civic Association, Shalom East, and Shalom South; and youth from the community.
Artists: Jonathan Laidacker, with mosaics by Mike Smash and Jonny Buss; participating students from Mural Arts AVRP (Adolescent Violence Reduction Program) sites at Lutheran Family Services, Carson Valley School, Mothers in Charge, Diversified Community Services, Norris Square Civic Association, Shalom East, and Shalom South; and youth from the community.
Location: Guerin Recreation Center – 17th & Jackson Streets



Mural Detail



Mural Design

Project: La Siempre Presente Fuerza Curatuiva (The Always Present Curative Force)
Theme: Destigmatizating Mental Illness
Completion Date: October, 2009
Partners: Maria de los Santos Health Center (a component of Delaware Valley Community Health, Inc.)
Artists: Cesar Viveros and Pedro Ospina
Location: Maria De Los Santos Health Center, 5th & Allegheny Avenue



Project: It's All About Community
Theme: Respect and understanding of persons with intellectual disabilities
Completion Date: May, 2010
Partners: Newbold Civic Association; representatives for the Department of Behavioral Health; the staff of Guerin Recreation Center; residents of the community; participating students from Mural Arts AVRP (Adolescent Violence Reduction Program) sites at Lutheran Family Services, Carson Valley School, Mothers in Charge, Diversified Community Services, Norris Square Civic Association, Shalom East, and Shalom South; and youth from the community.
Artist: Jon Laidacker, with mosaics by Mike Smash and Jonny Buss

Location: 6531-33 Germantown Avenue



The Porch Light Initiative

In 2009, the city of Philadelphia Mural Arts Program launched the Porch Light Initiative in collaboration with the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, the Scattergood Foundation, and subsequent funding from the Robert Wood Johnson Foundation. The Porch Light Initiative is developing a series of 9 large community-based public art projects in three disadvantaged neighborhoods that will focus on recovery from addiction, mental illness, and its related problems. Working through hub agencies in each neighborhood, the project will also provide people in recovery and their families with opportunities to express their experiences through such media as artwork, storytelling, poetry, and improv theatre. The goals of these projects are to decrease stigma related to these issues, increase access to behavioral health services, improve the physical and "psychological" environment in the areas of the murals and to have a positive impact on the participants in project's programming. To date, the following community-level projects have been completed or initiated.

Project: Finding Home
Theme: Hope for the Homeless
Completion Date: November, 2010
Partners: Project H.O.M.E. Bethesda, Lehigh Avenue Men's Shelter, Horizon House, 1715 Montgomery Aveneue Women's Shelter, Arch Street Café, St. John the Evangelist Catholic Church, and a cross section of safe haven sites across the city.
Artists: Josh Sarantitus, Kathryn Pannepacker, Alvin Tull, and Shelby Donnelly
Location: 13th Street behind SEPTA Headquarters



Project: Personal Renaissance
Theme: Addiction and Recovery
Completion Date: September, 2010
Partners: JEVS – ACT II, ProAct, youth from our ArtWorks site, Achieving Independence Center, and formerly incarcerated artists in our Re-Entry program.
Artist: James Burns **Photographer:** Mustafah Abdulaziz **Graphic Designer:** Rene Flint McCall
Location: Act II Center of JEVS Human Services building at 1745 N. 4th St.



The poem written by a person in recovery that appears in the upper right hand corner of the Personal Renaissance mural reads as follows:

Discovering Recovery
Empowering the person
That I am,
That I've become.
The one I always was and
Always have been,
Held down by my own hand
My own addiction
Our affliction
That effected everyone
My self, family and community
I am the positive face of
Recovery—see inside me—
My strength—my beauty
And hear my voice!
Take my fellow man/woman/
Divinity
Read the writing on my skin
And know we are akin
We are more alike than difference
What is good for me is good for you
We are one.

Project: Embrace Second Chances
Theme: Support for those in Recovery
Completion Date: October, 2009
Partners: CATCH (Citizens Acting Together Can Help)
Artists: Donald Gensler, assisted by University of Pennsylvania students and youth from the Mural Arts Program's Artworks program
Location: 1221 and 1211 South 15th Street



Projects Underway for 2011

Three mural projects in this behavioral health series are in the planning stage for 2011 as a result of a grant from the Robert Wood Johnson Foundation. The themes have yet to be decided for the new murals, but the neighborhoods have been selected. They include the neighborhoods near Sobriety Through Outpatient (STOP) (Zip Code 19132), Project H.O.M.E.—Rowan Homes (Zip Code 19121), and Asociación de Puertorriqueños en Marcha (APM) (Zip Code 19140). James Burns will lead STOP projects. Tony Award-winning spoken word artist Black Ice will collaborate with James Burns with poetry workshops. Betsy Casanas will lead APM projects. The artists team of Keir Johnston, Collette Fu, Claes Nina "Lyrispect" Ball, and Peri "Vizion" DiVirgillio will lead Project H.O.M.E. Rowan Homes. A major project about suicide prevention called Moving Towards the Light has started. Another project about Faith and Healing is about to begin with individuals from the Yoruba, Buddhist, Christian, and Jewish communities working with artists Joe Brenman, Henry Bermudez, and Josh Smith. Finally two other projects about immigration and children/trauma and resilience will begin later in 2011 and 2012.

Art, Personal Recovery, and Community Recovery

To evaluate what the experience of working on a recovery-themed mural meant to those who helped create the mural, one of the authors (W.W.) interviewed a number of the volunteers (persons in recovery and staff from participating service organizations) who worked on the recovery murals. Their voices suggest the profound and positive nature of these experiences.

Working on the mural has been the most positive part of my treatment experience.

There has been so much destruction in my life. This was an act of creation. It feels so good to look at the mural and know I was a part of making it.

What was great was everyone's involvement through the mural with people in the neighborhood and larger community. People who had not been involved in other program activities got very involved in the mural project. Art reaches people in a way that none of our other treatment activities can.

When you first get in recovery, there is so much craziness and so much of a vacuum to fill. Work on the mural helped fill that vacuum for me, and that's why I have continued to volunteer with the Mural Arts Project.

The fellowship with everyone [who worked on the mural] *was fabulous. We started out to create a mural and ended up creating a real community of people in recovery. We didn't have that before the mural project.*

Just to be able to do something positive was such an important part of my recovery.

Working with the Mural Arts Program is about service, fun and friendships, but it is also about finding hidden talents and elevating your sense of what is possible in your life. Volunteering to work on various mural projects helped give me a new identity and a new vision of what was possible for me. I now have my health and I have my kids back and I have people in my life who matter.

Addiction is so isolating….Many of us who helped create the mural have gotten into other community projects, but the mural was the beginning for a lot of us.

I just never realized what potential I had and I never felt I belonged before my work with Mural Arts. We've created some beautiful art, but we've also helped create some beautiful people.

I walk by the mural all the time and am in awe of its beauty. It still means a lot to me to know I had a hand in creating that.

My work with the mural was an important part of my early recovery. It was a time I could focus on something other than my problems—on something other than myself. The whole thing helped fill the void that drugs once filled for me.

> *That was a very special project. They involved us. They listened to us. They respected us. They told us we could do anything—that everything was possible for us.*

Philadelphia, through its Mural Arts Program, is discovering the power of art as an expression of community resilience and a vehicle of personal and community healing. In images that honor the past, freeze present moments, and excite future possibilities, Philadelphia is celebrating the resilience and character of its people and of the City itself. The murals that fill the city of Philadelphia are artifacts of a process of community resilience and recovery.

For more information about the Philadelphia Mural Arts Program and how it could be replicated in other cities, contact Jane Golden Heriza at jane.golden@muralarts.org.

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Acknowledgement: We would like to thank the following individuals for their assistance with this article: Cheryl Durgans, Amy Johnston, Anthony McLaughlin, Kyra Turner and those who participated in the interviews about their participation in the Mural Arts Program.

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Citation: Best, D. Groshkova, T, Sadler, J., Day, E. & White, W. (2011). What is Recovery? Functioning and recovery stories of self-identified people in recovery in a services user group and their peer networks in Birmingham England. *Alcoholism Treatment Quarterly*, 29(3), 293-313.Posted at **www.williamwhitepapers.com**

What is Recovery? Functioning and Recovery Stories of Self-identified People in Recovery in a Services User Group and their Peer Networks in Birmingham England

Abstract

The study was based on a peer snowballing method involving members of a service users group in Birmingham, United Kingdom, who were asked to identify and interview members of their peer networks who had achieved “sustained recovery” of one year. Two hundred and nineteen individuals were recruited who defined themselves as being in recovery, consisting of 132 individuals in medication maintained recovery and 87 in abstinent recovery. Those in maintained recovery were more anxious about using heroin and had lower self-efficacy, worse physical health, and poorer quality of life, and more peer group members still using. Being older was associated with greater quality of life (rather than time since last use) supporting a maturing out hypothesis.



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What is Your Recovery Quotient? Toward Recovery-focused Education of Addiction Professionals And Recovery Support Specialists

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The certification exams used to judge the competency of addiction professionals (from addiction counselors to physicians specializing in addiction medicine) rely almost exclusively on questions that test one's knowledge of the psychopharmacology of drugs, addiction and its related pathologies and the theories and methods of addiction counseling and treatment. Striking by their absence are questions about the stages, styles, pathways and processes of long-term recovery and the history and philosophies of American communities of recovery.

The following questions were developed in an afternoon of musing about the *recovery quotient* of addiction professionals and what an exam would look like that tested knowledge related to the history, theory, science and practice of non-clinical recovery support. There is nothing magical about these particular questions; I suspect on another afternoon I might come up with a quite different list of questions. But the questions included will sensitize the reader to the central point of this exercise: there is a body of knowledge about recovery that is quite distinct from the bodies of knowledge about addiction and addiction treatment.

The intent of this little quiz is to stimulate interest in the lived solutions to the problems many of us have devoted our lives to addressing. So take a few moments and evaluate your recovery quotient. Most of the topics imbedded in these questions are discussed in the papers posted at www.williamwhitepapers.com, in my book *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, and in my recent monograph *Peer-based Recovery Support: History, Theory, Science and Practice*.

I. True or False (6 points)

Place a T or F before each statement based on whether the statement is true or false.

___ 1. Smart Recovery grew out of a schism within Secular Organization for Sobriety.

___ 2. Methadone Anonymous is a recovery mutual aid society dedicated to helping people recover from methadone addiction.
____ 3. Between 1970 and 2010, the percentage of people working in addiction treatment who are in recovery has dropped precipitously--from nearly 70% to about 30% of the treatment workforce.
____ 4. The creation of Faces and Voices of Recovery grew out of the 2001 National Recovery Summit held in St Paul, MN.
____ 5. Faces and Voices of Recovery includes all recovery constituency groups except individuals and groups representing people in recovery from opioid addiction who are being treated with methadone.
____ 6. Nearly a third of MM members later choose abstinence-based recovery.

II. Multiple Choice Questions (25 points)

Answer each of the questions below by selecting the correct answer from the four choices presented.

___1. The earliest peer-led alcoholism recovery support effort in the United States from the list below is:
a. The Washingtonians
b. Alcoholics Anonymous
c. The Handsome Lake Movement
d. The Drunkards Club

___2. The first recovery mutual aid society birthed within an addiction treatment program was:
a. The Hazelden Alumni Association
b. The Ribbon Reform Clubs
c. The Keeley Leagues
d. The Ollapod Club

___3. Which of the following recovery mutual aid groups uses admission of “addiction” as a catalytic step in the recovery process?
a. Alcoholics Anonymous
b. Narcotics Anonymous
c. Cocaine Anonymous
d. Women for Sobriety

___ 4. The first President of the United States whose National Drug Control Strategy explicitly highlighted recovery and acknowledged “multiple pathways of recovery” was:
a. President Gerald Ford
b. President Jimmy Carter
c. President George W. Bush
d. President Barack Obama

___ 5. The fastest growing faith-based recovery mutual aid society in the United States is _____.
a. Celebrate Recovery
b. Millati Islami
c. JACS
d. Mountain Movers

___ 6. A national consensus conference convened by the Betty Ford Institute defined recovery as:
a. Continuous and uninterrupted sobriety
b. Remission (no longer meeting criteria for a substance use disorder)
c. Sobriety, progress towards global health and citizenship
d. Sobriety, spiritual awakening and progress toward global health

___ 7. This research team first pioneered the concept of “recovery capital.”
a. McLellan & Humphreys
b. Granfield & Cloud
c. Scott & Dennis
d. Miller and Kurtz

___ 8. This research team affirmed the value of post-treatment “recovery checkups”
a. McLellan & Humphreys
b. Granfield & Cloud
c. Scott & Dennis
d. Brown & Lewis

___ 9. This research team coined the term “trauma of recovery” to describe the destabilizing effects of early recovery on the family system.
a. McLellan & Humphreys
b. Granfield & Cloud
c. Scott & Dennis
d. Brown & Lewis

___ 10. Which of the following could be referred to as an “Eleventh Step” group?
a. Calix Society
b. Atheists and Agnostics in Alcoholics Anonymous
c. International Doctors in Alcoholics Anonymous
d. The Jacoby Club

___ 11. The first secular alternative to Alcoholics Anonymous was.
a. Secular Organization for Sobriety
b. Women for Sobriety
c. Rational Recovery
d. LifeRing Secular Recovery

___ 12. This research team christened the term “quantum change” to describe a climactic process of recovery initiation that is unexpected, unplanned, positive and permanent.
a. McLellan & Humphreys
b. Granfield & Cloud
c. Miller & C’de Baca
d. Scott & Dennis

___ 13. This researcher described acultural, bicultural and culturally enmeshed styles of recovery based on the degree to which an individual in recovery was involved in relationships with others in recovery.
a. Valliant
b. White
c. Best
d. Clark

___ 14. The stability point of recovery from alcohol dependence (the point at which the risk of future lifetime re-addiction drops below 15%) is ___ of continuous recovery.
a. 1 year
b. 2 years
c. 3 years
d. 4-5 years

___ 15. What two prominent Africans Americans from the list below were/are in recovery?
a. Booker T. Washington & W.E.B. Dubois
b. Frederick Douglass and Malcolm X
c. Jesse Jackson and Andrew Young
d. James Baldwin and Richard Wright

___ 16. Which prominent African America minister launched a, faith- and abstinence-based cultural revitalization movement in response to the crack cocaine epidemic in the Tenderloin District of San Francisco?
a. Reverend Cecil Williams
b. Father George Clements
c. Father Joseph Martin
d. Pastor Rick Warren

___ 17. In a now classic 1976 paper, she contrasted “scientific knowledge” and “experiential knowledge”, noting the latter was the primary source of knowledge within recovery mutual aid societies.
a. Lee Ann Kaskutas
b. Constance Weisner
c. Lois Wilson
d. Thomasina Borkman

___ 18. His 1979 book, *Not-God: A History of Alcoholics Anonymous,* stands as the definitive history of A.A.
a. Robin Room, PhD
b. Ron Roizen, PhD
c. Ernest Kurtz, PhD
d. Ollie Morgan, PhD

___ 19. Their 2001 article in the *Journal of the American Medical Association* helped spark the shift in addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management.
a. McLellan, Lewis, Obrien & Kleber
b. Humphreys, Tonigan & Moos
c. DuPont & Kleber
d. Rawson & Gold

___20. The idea of “community recovery” is best illustrated in the history of which of the following communities.
a. San Francisco, CA
b. Akron, OH
c. Alkali Lake, Canada
d. Mexico City, Mexico

___21. This recovery advocate and author used the metaphor of “healing forest” to convey the healing power of community and cultural renewal.
a. Don Coyhis
b. Stanton Peele
c. Mark Ames
d. Mark Sanders

___22. This sociologist formulated the “helper therapy principle” suggesting the therapeutic effects of helping others.
a. Carl Rogers
b. Frank Riessman
c. Jane Adams
d. Karen Horney

___ 23. This researcher confirmed the role of the helper principle as an active ingredient of participation in Alcoholics Anonymous
a. Sarah Zemore
b. Constance Weisner
c. Sharon Wegscheider Cruse
d. Claudia Black

___ 24. The first (1954) state to create a state civil service position for the role of alcoholism counselor was_____.
a. New York
b. Maine
c. Illinois
d. Minnesota

___ 25. He was the first recovering alcoholic to work as a “lay alcoholism therapist.”
a. Courtenay Baylor
b. Francis Chambers
c. Richard Peabody
d. Pat C.

III. The Geography of Recovery Movements (9 points)

Match the Organizations to an Associated Geographical Location (9 points)

____ Women for Sobriety	1. Lexington, KY
____ Addicts Anonymous	2. New York City, NY
____ Jacoby Club	3. Boston, MA
____ Drunkards Club	4. Quakertown, PA
____ Dashaways	5. Akron, OH
____ Narcotics Anonymous	6. San Francisco, CA
____ Alcoholics Anonymous	7. Silver Springs, MD

____ Oxford House	8. Van Nuys, CA
____ Keeley League	9. Dwight, IL

IV. Leaders within the History of Addiction Recovery Support (14 points)

Match these Leaders to their Respective Organizations

____ John Gough	1. Celebrate Recovery
____ Joe Gerstein	2. Alcoholics Anonymous
____ Clarence Snyder	3. Drunkard's Club
____ Jimmy Kinnon	4. Moderation Management
____ Jean Kirkpatrick	5. 16 Step Empowerment Groups
____ Orville Gardner	6. Women for Sobriety
____ Audrey Kishline	7. Blue Ribbon Reform Club
____ Francis Murphy	8. Royal Ribbon Reform Club
____ James Christopher	9. Narcotics Anonymous
____ Charlotte Kasl	10. Washingtonians
____ John Baker & Rick Warren	11. SMART Recovery
____ Henry Reynolds	12. Secular Organization for Sobriety
____ Paul Molloy	13. Oxford House
____ Jerry McAuley	14. Water Street Mission

V. The history of Recovery Mutual Aid Societies (12 points)

Rank the following from earliest to most recent with 1 being the earliest and 12 being the most recent.

____ Celebrate Recovery
____ Alcoholics Anonymous
____ Drunkard's Club
____ 16 Step Empowerment Groups
____ Women for Sobriety
____ Royal Ribbon Reform Club
____ Narcotics Anonymous
____ Washingtonians
____ SMART Recovery
____ Secular Organization for Sobriety
____ Methadone Anonymous
____ LifeRing Secular Recovery

VI. The Twelve Step Recovery Program (6 points)

Match the following for AA, NA and other Twelve Step Programs

____ Step One	1. Self-inventory
____ Step Four	2. Meditation and prayer
____ Step Five	3. Service
____ Step Nine	4. Acceptance
____ Step Eleven	5. Amends
____ Step Twelve	6. Confession

VII. Organizational Traditions of Twelve Step Programs (4 points)

Match the following for AA, NA and other Twelve Step Programs

____ Tradition Three	1. Financial Self-Support
____ Tradition Seven	2. Membership Requirement
____ Tradition Ten	3. No opinion on outside issues
____ Tradition Eleven	4. Anonymity at level of press

VIII. Recovery Concepts and Tools (8 points)

Match each of the following concept/tool to the organization with which it is most associated

____ Rational Recovery	1. “powerless over illicit drugs, including alcohol”
____ Women for Sobriety	2. 13 statements of “New Life” acceptance program
____ SMART Recovery	3. ABSTAR & nine step program
____ MM	4. 4 point program & ABCs of REBT
____ MA	5. AVRT
____ LifeRing Secular Recovery	6. “3-S Philosophy”
____ Secular Organization For Sobriety	7. Sobriety Priority
___ Celebrate Recovery	8. Eight Recovery Principles

IX. The New Recovery Advocacy and Peer Recovery Support Movements (14 points)

Connect the leaders below to the organizations with whom they have been affiliated

____ Bob Savage & Phil Valentine	1. PRO-ACT-Philadelphia
____Tom Hill	2. White Bison—Colorado Springs
____ Bev Haberle	3. MARS—New York City
____ Joe Powell	4. Recovery Consultants of Atlanta
____Don Coyhis	5. PRO-ACT-Philadelphia
____ Walter Ginter	6. Faces & Voices of Recovery
____ Pat Taylor	7. Speak-Out & Faces & Voices of Recovery
____ David Whiters	8. CSAT RCSP
____ Andre Johnson	9. Detroit Recovery Project
____ John Shinholser	10. RAP-Portland
____ Cathy Nugent	11. CCAR-CT
____ David Whiters	12 APAA-Dallas
____ Ron Williams	13. NCADD
____ Robert Lindsey	14. McShinn Foundation

Scoring

Score your test based on the following answers and then add your number of correct responses:

I. 1-F; 2-F; 3-T; 4-T; 5-F; 6-T

II. 1-C; 2-D ; 3-B ; 4-D ; 5-A ; 6-C ; 7-B ; 8-C ; 9-D ; 10-A ; 11-B ; 12-C ; 13-B ; 14-D ; 15-B ; 16-A; 17-D ; 18-C ; 19-A ; 20-C ; 21-A ; 22-B ; 23-A ; 24-D ; 25-A.

III. 4, 1, 3, 2, 6, 8, 5, 7, 9

IV. 10, 11, 2, 9, 6, 3, 4, 7, 12, 5, 1, 8, 13, 14.

V. 8, 4, 3, 9, 6, 2, 5, 1, 11, 7, 10, 12.

VI. 4, 1, 6, 5, 2, 12

VII. 2, 1, 3, 4

VIII. 5, 2, 4, 3, 1, 6, 7, 8

IX. 11, 7, 5, 12, 2, 3, 6, 4, 9, 14, 8, 4, 10, 13.

Best Possible Recovery Quotient Score: 100

My Recovery Quotient: ___



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Recovery Radio in Philadelphia

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Something quite remarkable is unfolding in communities around the world. More than at any time in human history, people who were once part of the global addiction problem are stepping forward with their families and allies to become part of the recovery solution. Secular, spiritual and religious addiction recovery mutual aid groups are spreading and growing in size. New grassroots recovery community organizations are rising in local communities and networking to form national and international recovery advocacy movements. New recovery support institutions are springing up—from recovery homes to recovery schools, recovery industries to faith-based recovery ministries, recovery cafes to recovery-focused sporting events. Vibrant cultures of recovery are spreading across the United States in tandem with these related trends. Within these cultures, the growing varieties of recovery experience are being expressed through ritual, symbols, language, music, art, dance, and theatre. Communication media of all varieties—from radio and television to film and Internet are being mobilized to carry recovery-focused messages of hope, help, and healing.

Nowhere is this recovery revolution and its vibrant cultures of recovery more evident than the City of Philadelphia—a city that has pioneered addiction treatment and recovery support resources for more than two centuries, a city that has hosted the largest recovery celebration marches in the world, and a city that has moved beyond hiding its problems to celebrating its solutions. Addiction flourishes in supportive communities and no community has done more to create the physical, psychological, and social space within which recovery can flourish than the City of Philadelphia. Earlier papers have profiled Philadelphia's recovery-focused transformation of its behavioral health care system (White, 2007), including its Recovery Advisory Committee, its consumer councils, recovery community centers, recovery murals, and some of its most creative and effective treatment and peer-based recovery support services (Achara-Abrahams, Evans, & King, 2011; Evans, Heriza, & White, 2011; Johnson, Martin, Sheahan, Way, & White, 2009; Maguire, Sheahan, & White, 2011; NET Consumer Council et al., 2007; White, 2009). The purpose of the present article is to profile recovery-themed radio programming in the City of Philadelphia.

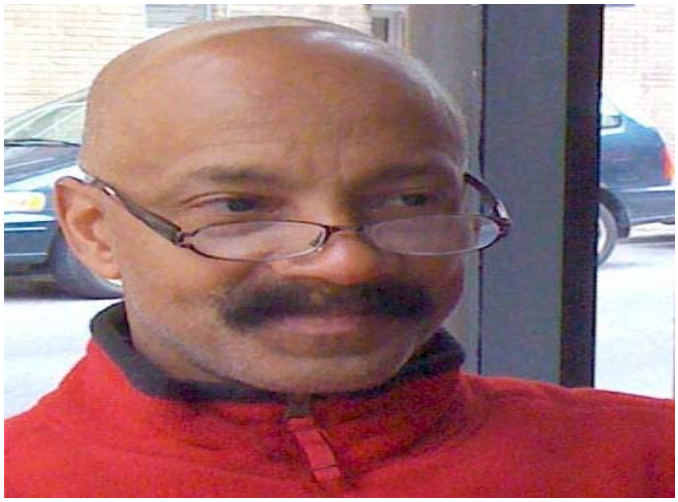
Recovery Radio: A Vision of Service

Where there is no vision the people perish. Proverbs 29:18.

Recovery radio in Philadelphia is inseparable from the fulfilled visions of three men: Derrick Ford, Vincent Faust, and Fred Barber.



In 2007, Derrick Ford had an epiphany while listening to local talk radio. He thought of all the talk radio shows spanning everything from politics to sports, astrology to cooking, and asked himself, "Why is there no talk radio focused on recovery?" Within a few minutes, he was able to visualize a program focused on recovery that could reach far more people than those currently "in the rooms" of local recovery support meetings. From that vision came a one-hour program that for the past five years has aired each Saturday night between 6-7:00 PM on WURD 900 AM. (http://tunein.com/radio/Rick-Ford-Show-p199387/)



In 2008, Mr. Frederick Heard, Executive Director, Sobriety through Outpatient (STOP), shared his idea of a client-run, recovery-themed radio show with staff member Vincent Faust. Fred knew that Vince had worked for years in radio before coming to STOP and challenged him to create Recovery Media—internet-based radio programming designed to engage people in recovery in therapeutic activities. Today, STOP streams through the Internet 20 hours of recovery-themed radio and television per week. (www.stop-recoveryradio.com

Fred Barber and two business partners launched a Philadelphia-based life-coaching business. In 2011, they decided that a radio show about recovery from addiction and mental health problems would be a great way to reach out to working people who were encountering behavioral health problems. The result is INSIGHT, a one-hour show each Monday night, 9-10 PM, on harambeeRadio.com—an internet-based radio program reaching African Americans in more than 30 cities. The URL for the program is:

http://www.harambeeradio.com/insight.htm
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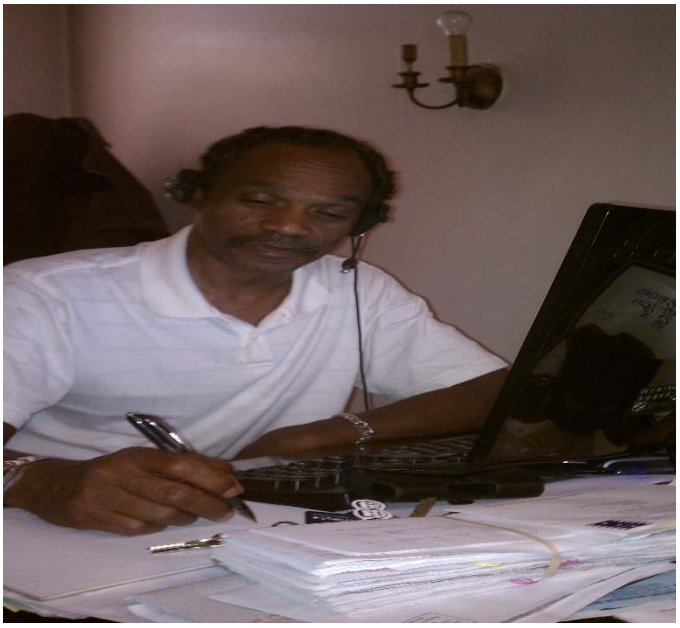

Recovery-themed Programming

Each of Philadelphia's recovery radio shows has its own style and format. The Rick Ford Show uses a live, call-in format featuring presentations and discussions. The show's guests represent a broad spectrum of Philadelphia's treatment and recovery support resources. STOP's Recovery Media features a series of shows on sports, health, fitness, poetry, and music—shows sporting such titles as Minds of Men, Men's Views, Women's Views, and Brutally Honest. INSIGHT features interviews with program directors, counselors, and people in recovery discussing behavioral health issues from a recovery perspective. Guests on the show range from national celebrities, local political figures, and local experts on treatment as well as people sharing the lived experience of recovery.

All three programs are designed as a forum for community outreach, with all of the shows linking people to resources where they can find help. That help is extended through conversations off line with people who call in for help and through the chat rooms linked to some of the shows. STOP's programming also illustrates the ways in which persons in treatment in Philadelphia are being actively engaged, empowered with new technical skills and confidence, and mobilized to give back to the community. The anonymity that can be afforded through radio programming also allows individuals in 12-Step recovery to share their stories and the resources that have helped them without violating personal anonymity at the level of press.

Philadelphia's behavioral health leaders view recovery radio shows as a beacon of hope within the City. Roland Lamb, Director of the Office of Addiction Services in Philadelphia, says the following about such programming.

> *Recovery radio in Philadelphia has been a beacon of hope for those who have lost their way and a source of guidance for individuals and families who are rebuilding their lives. Our City is very blessed to have these voices of expertise and experience reaching out every week to our citizens.*

Sponsorship of recovery radio programming in Philadelphia varies. Recovery Media and Insight are each self-sponsored, and the Rick Ford Show sponsors include Wedge Medical Center, Livengrin, Self-Help Movement, Men & Women for Human Excellence, NU-STOP, Northeast Treatment (NET), Self, Inc., Malvern Institute, One Day at a Time, and STOP.

Recovery Capital of the World

In my interviews with Derrick Ford, Vincent Faust, and Fred Barber, all acknowledged that their shows were part of the larger culture of recovery developing in Philadelphia. When asked about references to Philadelphia as the "recovery capital of the world," all agreed that this title was well-deserved and that Philadelphia has become "a Mecca" for people seeking and in recovery. They attributed this status in part to the recent leadership Dr. Arthur Evans brought to the City of Philadelphia's addiction treatment services, but they also acknowledged Philadelphia's deep historical recovery roots and their recent revival.

Personal Reflections

So who are the people behind these leading recovery radio voices in Philadelphia? Their lives are as remarkable offline as online. When not on the air, Derrick Ford works as a case manager and therapist with individuals experiencing substance use and co-occurring mental health disorders; volunteers for community programs—including the Brothers Reaching Back mentoring program, which he founded and directs—and raises his daughter, Quadia, as a single parent. Vincent Faust works full time as the Coordinator of Multimedia and Marketing at Sobriety Through Outpatient and invests his community service time with the Philadelphia Mural Arts Project, the Lupus Foundation, the Heart Association, the American Cancer Society, Women Organized Against Rape, and the Philadelphia Recovery Walk. Fred Barber works at the Wedge Recovery Center in Philadelphia (Program Director of the Germantown Education Center), serves as a volunteer at the Harmonious Volunteer Center, and shares with his wife the joy of seven grown children, including four college graduates, and two grandchildren.

When asked what this radio recovery ministry has meant to them personally, the responses included the following.

> *It's been an overwhelming experience for me—just understanding my niche, finding what God wants me to do. Helping others in this way has been so rewarding.*
>
> *I've always wanted to give back to the community for the support the community has given me. This was the way I found to give back.*
>
> *Personally, I just like the business of helping other people do better with their lives. It's given me another outlet to reach out to other behavioral health professionals and to reach out to people who are looking for a lifeline. And this is, of course, part of my own recovery process—to be able to pass on the hope of recovery. It's really gratifying to be able to be in this position—a real privilege.*

There is a recovery revolution in Philadelphia, and the revolution is being carried on the radio.

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Acknowledgement: Support for this interview series is provided by the Philadelphia Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS) and by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the DBHIDS, the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.



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Citation: Knudsen, H.K. & White, W.L. (2012) Smoking cessation services in addiction treatment: Challenges for organizations and the counseling workforce. Counselor, 13(1), 10-14. Posted at **www.williamwhitepapers.com**

Smoking Cessation Services in Addiction Treatment: Challenges for Organizations and the Counseling Workforce

Hannah K. Knudsen, Ph.D. and William L. White, M.A.

The question of how nicotine dependence should or should not be addressed within the context of addiction treatment has been a controversial issue from the inception of addiction treatment in the United States. Many nineteenth century inebriate asylums and private addiction cure institutes demanded cessation of smoking as a condition of treatment for other drug dependencies; bottled and boxed miracle cures for the "tobacco habit" were promulgated along side cures for alcoholism and morphine addiction, the first textbooks on addiction (then referred to as *inebriety*) included chapters on "tobaccoism," and intense debate raged in the first addiction medicine journal—the *Journal of Inebriety,* 1875-1914--on the relationship between nicotine addiction and other addictions and how and when it could be best treated (White, 1998). The debate continues more than a century later, but accumulating scientific findings, shifts in cultural attitudes toward smoking and growing clinical experience within addiction treatment are tipping the scales of this debate.

Current Context

Cigarette smoking remains one of the largest causes of premature death in the United States (Centers for Disease Control and Prevention, 2008). Individuals seeking addiction treatment are far more likely to smoke than the general adult population. About 21% of American adults smoke, but rates of smoking for clients in treatment range from 70-80% (McCarthy, Collins, & Hser, 2002; Richter, Ahluwalia, Mosier, Nazir, & Ahluwalia, 2002; Teater & Hammond, 2010; Williams & Ziedonis, 2004). Furthermore, people with substance use disorders (SUDs) consume more cigarettes per day, which further increases the risks to their health (Sussman, 2002). Long-term studies have shown that cigarette smoking is more likely to result in premature death for individuals with SUDs than their alcohol or drug use (Hser, McCarthy, & Anglin, 1994; Hurt, et al., 1996).

There is a growing body of research examining how smoking impacts recovery after treatment as well as the effectiveness of smoking cessation interventions for people with SUDs. Quitting smoking in the first year of SUD treatment increases clients'

likelihood of achieving recovery, even 9 years after treatment (Tsoh, Chi, Mertens, & Weisner, 2011). Continuing to smoke after treatment is actually a risk factor for relapse (Kohn, Tsoh, & Weisner, 2003; Satre, Kohn, & Weisner, 2007). Strengthening the case for the importance of smoking cessation interventions is a meta-analysis by Prochaska and colleagues (2004). They reviewed the existing research and concluded that these interventions increase the likelihood of short-term smoking cessation and improve the chances of long term SUD recovery. Other recent reviews have also concluded that smoking cessation is an important clinical goal for SUD treatment (Baca & Yahne, 2009; Prochaska, 2010; Schroeder & Morris, 2010).

Clinical practice guidelines also call for the integration of smoking cessation services into SUD treatment. Most notably, the US Public Health Service has published the clinical practice guideline, *Treating Tobacco Use and Dependence: 2008 Update*, which recommends that all health care providers counsel their patients about tobacco use and provide interventions—ranging from counseling to medications—to help patients quit smoking (Fiore, et al., 2008). The guideline specifically addresses SUD treatment providers, recommending that they deliver smoking cessation interventions to their clients. These interventions are also recommended in the National Institute on Drug Abuse guideline, *Principles of Drug Addiction Treatment: A Research-Based Guide* (NIDA, 2009).

New Scientific Findings

In 2006, a study began at the University of Georgia that sought to increase knowledge about the adoption and implementation of smoking cessation interventions in SUD treatment programs. Our interests were twofold. First, we wanted to learn about how many treatment organizations offered counseling programs and medications for smoking cessation, while identifying the types of organizations more likely to offer these services. Second, we hoped to collect innovative data from counselors about implementation, meaning how routinely counselors delivered smoking cessation interventions as part of their everyday work. By gathering information from both administrators and counselors, we sought to conduct one of the most comprehensive studies about smoking cessation services in addiction treatment centers throughout the US.

Our research methodology built upon the National Treatment Center Study (NTCS), which is a large-scale health services research project that recruited administrators from more than 1,100 treatment organizations to participate in face-to-face interviews between 2002-2004. [More information about the larger NTCS can be found in publications by Dr. Paul Roman and colleagues; see Roman, Ducharme & Knudsen (2006) and Dye et al. (2009).] The NTCS included nationally representative samples of publicly funded treatment agencies, privately funded treatment organizations, and therapeutic communities, which were re-contacted by telephone in 2006-2008. About 86% of these programs participated in telephone interviews about smoking cessation services. After the interview, we invited administrators to provide lists of counselors working at their treatment programs. Counselors were mailed surveys, and we received more than 2,100 surveys from counselors across the US.

The Adoption of Smoking Cessation Services in SUD Treatment

One goal of the study was to document the extent to which treatment organizations had adopted smoking cessation services (Knudsen, Studts, Boyd, & Roman, 2010). Adoption refers to the availability of these services. We focused on three types of services: brief interventions delivered during intake, counseling-based smoking cessation programs, and medications to treat nicotine dependence. The brief intervention of asking new clients if they currently smoked had been adopted by nearly all programs (86%), but far fewer programs (35%) helped motivated clients to

develop a quit plan.

The three samples of treatment organizations differed in their rates of offering smoking cessation programs and medications. About 71% of publicly funded treatment programs and 65% of therapeutic communities did not offer a counseling-based smoking cessation program or any medications, such as over-the-counter nicotine replacement therapy (NRT) or prescription medications (e.g., varenicline, sustained-release bupropion). Programs that relied on private sources of funding, like insurance and self-paying clients, were more likely to offer services, but the predominant approach offered by 41% of private programs was smoking cessation medications without a formal counseling program.

We sought to identify the types of treatment organizations that were more likely to offer comprehensive smoking cessation services, meaning both a counseling-based program and medications. This type of comprehensive approach is highly consistent with current clinical practice guidelines, although it was only adopted by 11% of programs. Statistical models compared programs offering comprehensive services to those that offered neither a counseling program nor medications. Comprehensive services were more likely to be found in hospital-based programs, larger treatment organizations, and those offering only inpatient/residential levels of care. There were three cultural barriers to comprehensive services. Programs reporting that smoking was not important in treating SUDs, that there was no time to integrate smoking cessation into their existing treatment protocols, and that they lacked staff with smoking cessation counseling skills were less likely to offer comprehensive smoking cessation services.

The larger NTCS had previously collected information about adoption of nicotine replacement therapy (NRT), so we compared rates of NRT adoption between 2002-2004 and 2006-2008 (Knudsen & Studts, in press). There was a small decrease over time, from 38% to 34% of programs offering NRT. While that seems like a very modest change, it actually does not fully capture the changes that occurred within these programs over time. About 16% of programs discontinued using NRT between the two time-points, while 12% of the sample started using NRT by 2006-2008. We found that 21% of programs used NRT at both time-points, indicating sustained adoption within these programs.

Implementation of Smoking Cessation Interventions

While adoption reflects organizational decisions about offering a given service, counselors play a central role in the actual delivery of psychosocial interventions, such as smoking cessation counseling. In other words, counselors are the drivers of implementation. They can influence whether smoking cessation counseling becomes a routine part of addiction treatment. Survey from more than 2,100 counselors measured the extent to which they were delivering brief interventions and counseling sessions dedicated to smoking cessation.

Many counselors are making a concerted effort to ask new clients about whether they use tobacco products, but counselors less frequently implement other brief interventions such as advising smokers to quit, assessing willingness to quit, and trying to increase motivation to quit (Knudsen & Studts, 2010). Delivery of counseling sessions that are dedicated to smoking cessation are rare (Knudsen, Studts, & Studts, in press), which is not surprising given the small number of organizations offering a counseling-based smoking cessation program.

We sought to better understand the factors related to higher levels of implementation for both brief interventions and counseling sessions (Knudsen & Studts, 2010; Knudsen, et al., in press). Three key factors were identified. First, counselors who reported that program managers were supportive of smoking cessation services more frequently delivered brief interventions and counseling sessions dedicated to smoking cessation. Second, counselors who reported greater knowledge about the PHS

guideline, *Treating Tobacco Use and Dependence*, engaged in greater implementation. Finally, counselors who believed that smoking cessation would improve clients' chances of recovery reported greater implementation of both brief interventions and counseling sessions focused on smoking cessation.

One issue that has been discussed in the literature is the role of counselors' personal tobacco use as a factor in their implementation of smoking cessation counseling (Guydish, Passalacqua, Tajima, & Manser, 2007). In our sample, about 20% of counselors were current tobacco users. Our findings about the implications of counselor tobacco use were mixed. On the one hand, current tobacco users implemented brief interventions less frequently than counselors with no history of tobacco use (Knudsen & Studts, 2010). However, there was no difference in the implementation of counseling sessions between current tobacco users and counselors who had never been tobacco users (Knudsen, et al., in press).

Future Trends

Having been involved in documenting the history and evolution of smoking-related practices within the field, we would offer the following six predictions regarding the future of this issue within the field.

1. Smoking as a Recovery Advocacy Issue: Given the high smoking-related death toll of people in recovery, recovery advocacy organizations will increasingly address nicotine addiction at a national policy level and in their advocacy of changes in local addiction treatment practices.

2. Challenging Myths and Misconceptions about Nicotine Addiction, Addiction Treatment and Recovery: A massive educational effort will extend over the next decade and fundamentally alter how the addiction treatment field has historically addressed (or failed to address) the issue of nicotine dependence among its service providers and service recipients.

3. Institutional Smoking Policies: Funding, regulatory and accreditation bodies will demand ever-increasing rigor in how addiction treatment programs address the issue of smoking as a public health issue (e.g., non-smoking policies on treatment campuses) and a clinical issue (e.g., standards for assessment, treatment and post-treatment recovery support services related to nicotine dependence).

4. Smoking Cessation Support Services: Assessing nicotine dependence at intake, incorporating nicotine cessation into treatment and recovery plans, providing counseling-based nicotine addiction treatment, providing medications to support cessation of nicotine dependence, and providing peer-based support services to aid recovery from nicotine dependence will become standards of practice in all addiction treatment programs.

5. Mobilizing Experiential Knowledge: Efforts will be made to formally integrate the experiential knowledge of the 48% of addiction counselors who are former smokers to support fellow staff and patients to achieve stable long-term recovery from nicotine dependence.

6. Counselor Training Programs: Smoking will be increasingly defined as an ethical and professional practice issue for addiction professionals (See White, 2008), and addiction counselor training programs will increasingly integrate additional knowledge and skills training related to the counseling and medical treatment of nicotine dependence.

Addiction counselors are speeding the advent of these changes through their personal advocacy, refinement of their counseling practices and, in increasing numbers, severing their own relationship with nicotine.

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Acknowledgements

The authors gratefully acknowledge research support from the National Institute on Drug Abuse (R01DA020757, R01DA13110, R01DA14482, and R01DA14976). Research collaborators on the national study of smoking cessation practices included Dr. Paul M. Roman from the University of Georgia and Dr. Jamie L. Studts, Dr. Tina R. Studts, and Ms. Sara Boyd from the University of Kentucky. The opinions expressed are those of the authors and are not intended to represent the official position of NIDA.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Best, D., Honor, S. Karpusheff, J., Loudon, L. Hall, R., Groshkova, T. & White, W. (2012) Wellbeing and recovery functioning among substance users engaged in post-treatment recovery support groups. *Alcoholism Treatment Quarterly*, 30, 397-406. Posted at **www.williamwhitepapers.com**

Well-Being and Recovery Functioning among Substance Users Engaged in Post-treatment Recovery Support Groups

David Best, Stuart Honor, Justine Karpusheff , Lorraine Loudon, Reg Hall, Teodora Groshkova & William White

Abstract

There is a growing literature that seeks to evaluate the role of ‘‘recovery capital’’ in the resolution of substance use disorders. In this study, a structured instrument (the Assessment of Recovery Capital), along with an assessment of social networks among 176 former illicit drug users and drinkers, is measured in three locations in England. There were relationships between recovery capital and vocational activity (training or employment), physical health, psychological health, and overall quality of life, with larger social networks associated with enhanced personal and social recovery capital. The study demonstrates high levels of personal and social well-being—manifesting in engagement in community activities and strong social networks—among persons engaged in recovery support activities that was not linked to time in recovery.

KEYWORDS Recovery capital, quality of life, social networks, meaningful activities



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: Why Recovery? Why now? Opening Remarks at the 2012 UCLA / Betty Ford Institute First Annual Recovery Conference. Posted at **www.williamwhitepapers.com**

Why Recovery, Why Now?

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Introductory Note: On February 21-23, 2012, the Betty Ford Institute, in collaboration with UCLA, sponsored the fourth in a series of recoverythemed consensus conferences. Held at the Betty Ford Center in Rancho Mirage, CA, the conference was attended by federal policy leaders (ONDCP, NIAA, and NIDA), addiction research scientists, recovery advocates, and recovery support specialists. Below are my welcoming remarks to those attending.

I have been asked tonight to set the stage for our conference by offering a few remarks related to three questions: 1) Why recovery? 2) Why now? 3) Why this conference? Ironically, this may be the one group of people in the world who could each provide a detailed response to these questions.

Why Recovery?

Historians place the rise of a specialized field of study and professional intervention into alcohol and drug problems between the late 18th and mid-19th centuries. In the time since, the alcohol and drug (AOD) problems arena has been dominated by two organizing frameworks: a pathology paradigm that assumed long-term solutions to these problems would be revealed through the study of the etiology, patterns, course, and personal and social outcomes of AOD problems, and an intervention paradigm that assumed solutions to AOD problems could be found in rigorously evaluating social and clinical interventions into these problems. These organizing frameworks have produced a voluminous quantity of scientific and clinical knowledge, but their limits have set the stage for a more solution-based framework focusing on the study of resilience, resistance, and recovery. I want to share a few thoughts about the importance of this new recovery frontier.

As a country, we have offices, institutes, and centers of “drug control,” “drug abuse,” “alcohol abuse and alcoholism,” and “substance abuse treatment” but no offices, institutes, or centers of recovery. As a field, we have journals of addiction, addiction research and theory, addictive behaviors, addictive diseases, alcohol research, alcoholism, alcohol and drugs, drug and alcohol abuse,

drug and alcohol dependence, drug and alcohol studies, psychoactive drugs, drug issues, drug problems, drug policy, substance abuse, ethnicity in substance abuse, substance use and misuse, as well as journals of alcoholism treatment, substance abuse treatment, and maintenance in the addictions, but only one journal that even contains the word recovery in its title (Journal of Groups in Addiction and Recovery) and no journal specifically focused on the science of addiction recovery. We have addiction technology transfer centers, but no recovery technology transfer centers; addiction studies programs but no recovery studies programs; addiction medicine specialists and addiction professionals but until very recently, no recovery specialists.

As a result, the etiological pathways into AOD problems have been well-charted, but pathways and styles of long-term addiction recovery remain a rarely explored frontier. The national prevalence and patterns of AOD use and related problems are surveyed every year, but there are no comparable systematic surveys of the prevalence and patterns of recovery. More importantly, the professional and scientific community has failed to provide answers to some of most important questions faced by people in recovery. The normative stages and strategies of long-term personal and family recovery are not available to those who most need this information except “in the rooms” of mutual aid groups where the only scientists present are there to support their own recoveries.

The challenges and opportunities of living in recovery across the life cycle have not been mapped. The addiction pathologists tell those of us in recovery that our children are at increased risk of developing AOD problems, but they offer no information on whether or how our recovery status alters that risk, no information on parenting strategies that might alter their vulnerability or enhance their future early recovery prospects. People are entering recovery younger and younger, and yet little information exists about living a life in recovery that begins at age 15 or 25 rather than 45 or 55. There is a large cohort of people in long-term recovery facing late life challenges: loss of parents, siblings, spouses, children, sponsors, and friends; adult children returning home; impairing and life-threatening medical conditions; acute and chronic pain; proffered medication remedies; loss of work or retirement; financial distress; and other late life issues. Some within this cohort experience a reoccurrence of addiction after years of stable recovery. As communities of people in long-term recovery turn to addiction scientists and clinicians in search of guidance on such issues, we find little recognition of our existence and little guidance. So we turn to each other and wonder collectively why after decades of research investment, our most basic questions about recovery remain unanswered.

What we know about alcohol and drugs, addiction, and the short-term treatment of addiction fills libraries, and this knowledge has helped many people start their recovery journey, but what we know as a professional field about long-term personal and family recovery from addiction from the standpoint of science and clinical practice could at best barely fill a few scant shelves within such libraries (and most of these would be unpublished dissertations).

In 2011, more than 100,000 individuals and families in recovery and their friends and allies marched in more than 200 U.S. recovery public celebration events during Recovery Month. Hundreds of thousands of people in recovery are today standing publicly, declaring their existence, and calling for recovery support resources and a recovery research agenda. They are suggesting that it is time we tapped the large well of lived recovery experience and used the lessons from such experience to build on what we have learned from the study of addiction pathology and brief addiction treatment.

Why Now?

As to the “Why Now?” question, there are several potential answers historically, but one stands out in prominence. For decades, we have been concerned about bridging the chasm between research and practice in addiction treatment with the implicit assumption that research knowledge was far ahead of clinical practice. In the recovery arena, in marked contrast, we need a practice to research initiative. Put simply, practice is far ahead of the research. The growth and diversification of recovery mutual aid; the recovery advocacy movement; new recovery support institutions; the emergence of recovery as a new federal, state, and local organizing paradigm; widespread experiments with recovery management (RM) and recovery-oriented systems of care (ROSC) sparked by the pioneering work in Connecticut and Philadelphia; and new service roles, particularly the role of recovery coach, are transforming the recovery landscape in the United States and beyond in ways that are profoundly affecting and will affect the future of addiction treatment and recovery. Policy-makers, research scientists, and addiction professionals, where not oblivious of this fact, are running to catch up. I would suggest that the window of time for them to serve this broader movement or to create the illusion that they are leading it is a narrow one.

Why a Meeting of This Kind?

As to why there is a need for an annual recovery conference, the answer is quite clear. At present, thousands of recovery-focused initiatives are underway across the U.S., but there is no structure for connecting the dots to understand the picture of what is unfolding or to evaluate the impact of these projects at either a local or global level. We need to regularly gather key people from diverse stakeholder groups to evaluate what is emerging in this shift towards a recovery paradigm and to create a forum for consensus and advocacy statements. Such a forum will help facilitate alignment of research, policy, and service practice to support long-term recovery; enhance quality of personal and family life in long-term recovery; break intergenerational cycles of problem transmission; and create a larger healing force within American communities wounded by AOD and related problems. The exemplary contributions and unique perspectives of those assembled for this meeting offer us a unique opportunity to achieve this vision. I wish each of us Godspeed on our journey into this new recovery frontier.



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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2015). Obituary: Ernest ("Ernie") Kurtz (1935-2015). *Addiction*, 110(7), 1205-1206. Posted at **www.williamwhitepapers.com**

Obituary
Ernest (Ernie) Kurtz, 1935-2015

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Ernest Kurtz, the Harvard-trained scholar best known for his definitive history of Alcoholics Anonymous (A.A.) [1], died at the age of 79 on January 19, 2015. His later studies focused on guilt and shame [2], spirituality and its role in addiction recovery [3], and the growing varieties of A.A. and addiction recovery experience [4-6]. He remained active as a seminal thinker, teacher, and mentor, with his last book [7] completed in 2014 and his last scholarly paper [8] completed only days before his death.

Ernie was born in 1935—the year A.A. was founded—in a German neighborhood of Rochester, New York, the oldest child of Edward and Josephine Kurzejewski. He attended St. Bernard's Seminary and College in Rochester and was ordained as a Catholic priest. During his parish work, he took psychology courses at the University of Rochester and then entered Harvard University where he completed a PhD in the History of American Civilization in 1978. Having himself been treated for alcoholism in the mid-1970s, the potential for studying A.A. arose when A.A. established an archive containing all of its previously unavailable historical documents. After convincing his Harvard dissertation committee and the A.A. Trustees' Archives Committee of the need for a scholarly history of A.A., Ernie completed his dissertation and subsequently revised and published it as a book.

Following publication of *Not-God: A History of Alcoholics Anonymous* in 1979, Ernie served as Director of Research and Education at Guest House, taught at the University of Georgia and Loyola University of Chicago, and later served as an Adjunct Research Scientist at the University of Michigan's departments of social work and psychiatry. In the 1980s, he left the priesthood, married Linda Farris, and established himself as one of the premier alcoholism educators at venues such as the Rutgers University Summer School of Alcohol Studies. In the early 1990s, Ernie began exploring how the core spiritual

experiences of recovery within A.A. (release, gratitude, humility, tolerance, forgiveness, and being-at-home) might hold meaning for a much broader audience. This led to collaboration with Katherine Ketcham on the book, *The Spirituality of Imperfection*, which has sold more than 250,000 copies, and its recent follow-up, *Experiencing Spirituality*.

Ernie's most noted work, *Not-God,* marked the beginning of his decades-long research on A.A. and the broader history of alcoholism recovery. Much of this work involved debunking misconceptions about A.A. and elucidating the differences between A.A. and professionally directed addiction treatment [9-10]. Ernie believed recovery mutual aid and professional interventions each had value as an aid to long-term addiction recovery, but that their integrity and value were diminished when their distinguishing characteristics were diluted or lost. Ernie found the growing pathways of long-term addiction recovery cause for celebration, whether it was in his support of atheists and agnostics in A.A. or his support of those establishing recovery support alternatives to A.A., including his early support for the development of Moderation Management. He played a leading role in the development of the *Guide to Mutual Aid Resources* developed by the U.S.-based recovery advocacy organization, Faces and Voices of Recovery [11].

In his explorations of A.A. and spirituality, Ernie always returned to the transformative power of story reconstruction, storytelling, and story listening. In a recent interview, he noted: "All stories require a context, and for the kind of stories told in A.A.—spiritual stories, however weird that claim may sound to some—there is something about an A.A. story that makes sense, that can be truly heard, only within a community of listeners, of fellow hearers who are making an effort to identify with the story-teller, to absorb her or his story into their own" [12].

Ernie was above all a teacher, mentoring generations of scholars wishing to explore the history of A.A. and the larger history of addiction recovery. It is hard to find a thesis or dissertation on A.A. or recovery mutual aid that does not acknowledge his contributions and guidance. Ernie repeatedly challenged those of us working on advancing the history of addiction treatment and recovery to adhere to his six suggested guidelines: 1) tell the story chronologically, 2) tell the story in context, 3) document the historical evidence—ALL of the evidence, 4) clearly separate fact from conjecture, 5) tell the story from multiple perspectives, and 6) localize and personalize the story [13]. He demanded a rigorous level of scholarship and could be harsh when that standard was not met, but he always raised the quality of work of those he mentored.

Ernie's intellectual curiosity was wide ranging, but he often returned to the subject of A.A.'s historical significance within the larger history of ideas and what A.A. meant to those suffering from alcoholism. He insisted that "A.A.'s revolutionary contribution was not medical diagnosis of the 'disease' of alcoholism but its insistence that the most important reality in the life of the alcoholic, sobriety, could not be attained alone" [14]. As historian, teacher, master storyteller, research colleague, and friend, he gifted us with his intellect, his integrity, and his open offers of assistance.

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